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Michael T. Flannery

University of Arkansas at Little Rock William H. Bowen School of Law, mxflannery@ualr.edu

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ARTICLES

MUNCHAUSEN SYNDROME BY PROXY: BROADENING THE SCOPE OF CHILD ABUSE

*Michael T. Flannery**

[O]ur great creative Mother, while she amuses us with apparently working in the broadest sunshine, is yet severely careful to keep her own secrets, and, in spite of her pretended openness, shows us nothing but results.¹

In July 1989, five-month-old Ryan Stallings spent two weeks in a hospital after suffering abdominal pains.² Ryan was subsequently placed in a foster home when police suspected that he ingested antifreeze while in the care of his mother, twenty-four-year-old Patricia Stallings.³ Police became suspicious of Patricia because Ryan could not walk and thus was unlikely to ingest antifreeze accidentally.⁴ Patricia was allowed to visit Ryan once every week while he remained in foster care under the supervision of the Missouri Division of Family Services.⁵ Shortly after her visit on August 31, 1989, Ryan was readmitted to the hos-

* Associate, Gold-Bikin, Clifford & Young, B.A., 1987, The University of Delaware; J.D., 1991, The Catholic University of America, The Columbus School of Law.

1. NATHANIEL HAWTHORNE, *The Birthmark*, reprinted in *YOUNG GOODMAN BROWN AND OTHER SHORT STORIES* 14 (Stanley Appelbaum ed., Dover Publications, Inc. 1992) (1854).

2. Lou Jakovac, *Mother Is Accused of Twice Poisoning Infant Son*, ST. LOUIS POST-DISPATCH, Sept. 7, 1989, at 14A.

3. *Id.*

4. *Id.*

5. *Id.*

pital with symptoms similar to those prompting his hospitalization in July.⁶ Hospital personnel again suspected that Ryan had antifreeze in his blood. Consequently, the police charged Patricia Stallings, five months pregnant with her third child, with first-degree assault for feeding antifreeze to her son.⁷ The charges were upgraded to first-degree murder when Ryan died after several days of suffering in the hospital.⁸ An autopsy revealed that Ryan had traces of ethylene glycol, an antifreeze ingredient, in his body.⁹ Consequently, prosecutors sought the death penalty.¹⁰ Patricia Stallings was described as a "very loving mother" who lived to take care of her baby.¹¹ In fact, she may be considered a typical mother of a child suffering from Munchausen Syndrome by Proxy.¹²

I. INTRODUCTION

As society progresses into the mid-1990s and the number of incidences of child abuse and neglect continues to increase at an alarming rate,¹³ professionals in the child protective service

6. *Id.*

7. *Id.*

8. Carolyn Bower, *Death Penalty Will Be Sought: Young Mother Is Accused of Poisoning Her 5-Month-Old Son*, ST. LOUIS POST-DISPATCH, Sept. 9, 1989, at 1A.

9. *Id.*

10. *Id.*

11. *Id.*

12. For a discussion of the Stallings case and its relation to Munchausen Syndrome by Proxy, see Karen Schmidt, *Odd Malady Borrows Trouble; Bizarre Illness Pits Parent Against Child*, HARTFORD COURANT, Jan. 16, 1994, at A1.

13. Surveys from 1991 show that more than 2000 children die each year in America as a result of intentional injuries inflicted by caretakers. Michael J. Durfee et al., *Origins and Clinical Relevance of Child Death Review Teams*, 267 JAMA 3172, 3172 (1992); Sonia Nazario, *When Cries For Help Go Unheard*, L.A. TIMES, Mar. 28, 1993, at A7. These numbers will increase each year as child fatalities due to abuse and neglect are more easily identified and more readily reported. Durfee, et al., *supra*, at 3172.

Since 1985, abuse reports have increased by 50%. Patricia Edmonds, *1 Million Young Victims—And Counting*, USA TODAY, Apr. 7, 1994, at 2A; Gale Holland, *High-Profile Abuse Cases May Not Shed Much Light*, SAN DIEGO UNION TRIB., Jan. 10, 1994, at A-3. However, since 1976, reports of child abuse and neglect have increased by 400%. *Child Abuse: Growing Problem In the USA*, USA TODAY, April 7, 1994, at 8A.

In 1982, there were 1.2 million children reportedly abused or neglected. *Hearing on Funding to Improve the Prosecution of Child Abuse Before the House Appropri-*

ations Subcommittee on commerce, Justice and State, the Judiciary and Related Agencies, 103rd Congress, 2d Sess. (April 27, 1994) (statement of William C. O'Malley, president of the National District Attorneys Association). In 1986, 2,086,000 cases of child abuse were reported, and researchers speculated that two thirds of abuse cases remained unreported. Eric B. Leavitt et al., *Otolaryngologic Manifestations of Child Abuse*, 118 ARCHIVES OTOLARYNGOLOGY HEAD NECK SURGERY 629, 629 (1992). By 1994, this number increased to almost three million—one report every 10 seconds—and two million more than in 1992. Jonetta R. Barras, *Abuse, Neglect of Children Soars in Area Since '77: Drugs Are Called 'Pervasive' Factor*, WASH. TIMES, Sept. 9, 1993, at B1; Edmonds, *supra* note 13, at 2A; Sharman Stein, *Dilemma in Child Abuse, Foes Say Care Stymied by False Reports*, CHI. TRIB., Apr. 7, 1993, at N1; Margaret Wimborne, *Group Helps People Accused of Abuse*, IDAHO FALLS POST REG., Oct. 6, 1993, at C8 (stating that the National Committee for the Prevention of Child Abuse showed three million children were suspected of being abused in 1992). Cf. Mark Sauer & Jim Okerblom, *Trial By Therapy; The Case of Alleged Child Abuser Dale Akiki*, 45 NAT'L REV. 30 (Sept. 6, 1993) (stating that 59% of child abuse reports made in 1992 were unsubstantiated).

Orange County, California received 36,000 complaints of child abuse in 1993—a 28% increase since 1989. Tammerlin Drummond, *Conference Helps Clergy Handle Child Abuse Cases*, L.A. TIMES, May 11, 1994, at B1. While this number is lower than the statewide average, the rate of increase for Orange County outpaces both state and national averages. Kevin Johnson, *Child Abuse, Poverty Up, O.C. Report Shows*, L.A. TIMES, Oct. 14, 1993, at A1. Westchester County in New York suffered a 148% increase in cases between 1980 and 1990 despite a 13.4% decline in the number of children. Elsa Brenner, *County's Children, by the Numbers*, N.Y. TIMES, Feb. 20, 1994, § 13WC, at 21. Washington, D.C. has incurred an increase in child abuse cases of 386% since 1977 with a child population increase of only 8.2%. Barras, *supra* note 13, at B1.

Of the nearly three million reports of child abuse nationwide in 1993, Arizona experienced 30,407 reports—an increase of 260% since 1980. *The Grim Increase of Child Abuse Cases: Social Workers Are Seeing More Maltreatment, Serious Injuries*, PHOENIX GAZETTE, Apr. 5, 1994, at A1. Missouri accounted for 50,000 of these reports despite having received only 5,000 reports of abuse in 1975. *Cool Off the Hot Line*, ST. LOUIS POST-DISPATCH, Jan. 24, 1994, at 6B. Illinois added another 130,572 to the 1993 statistics and experienced an increase of 22%, one of the highest increases between 1991 and 1992. Stein, *supra*, note 13, at N1. New York state accounted for 227,000 of the total reports made in 1992, of which 52,000 came from New York City alone. Graham Rayman, *Child Abuse Up After a Year's Decline in NY*, NEWSDAY, June 18, 1993, at 3.

The state of Massachusetts averages 245 reports of abuse or neglect on a daily basis. David Arnold, *United Way Puts Its Money on City's Youngest*, BOSTON GLOBE, Apr. 26, 1994, at 23. Recently, the Superior Court of the District of Columbia received in one day a record of 29 referral cases involving abuse or neglect. Nancy Lewis, *Child Neglect Cases Break Daily Record in D.C. Court*, WASH. POST, May 10, 1994, at A1. Figures for 1994 could reach 2,500 in the District of Columbia if the current figures continue at a steady rate. *Id.* at A6. However, whereas in most states and individual counties the number of child abuse reports increases steadily, some cities or counties report a decrease in the number of new reports. *See, e.g.*, Arnold, *supra* note 13, at 23 (referring to Milwaukee, Wisconsin which witnessed a 10% decrease in reported child abuse in 1993).

field, including medical professionals, are becoming more aware of the need to identify, report, and address "suspected cases" of child abuse.¹⁴ Although some commentators argue that the increased number of cases of abuse and the consequent overzealous reporting may result in exaggerated statistics,¹⁵ reports are generally made out of genuine concern for the welfare and safety of the child. Of course, child welfare professionals must use their educated discretion to distinguish cases of overly protective reporting from cases that clearly warrant intervention and may have medical or legal ramifications. However, the relatively recent medical diagnosis known as Munchausen Syndrome by Proxy has added another dimension to the difficulties faced by child welfare professionals, medical professionals, and the courts in identifying and dealing with abused children.¹⁶

14. Several reasons cited for the increased reporting of child abuse are continuing problems of substance abuse, stricter reporting requirements, and increased public awareness. N.Y. TIMES, May 2, 1994, at B1. See Barras, *supra* note 13, at B1; Edmonds, *supra* note 13, at 2A; Lucille Renwick, *Recession Propels Increase in Child Abuse*, L.A. TIMES, Mar. 20, 1994, at 3. (referring to Los Angeles County);

Every state statutorily enumerates those mandated to report suspected cases of child abuse. In all cases, these reporters include, but are not limited to, medical professionals. For a list of state reporting statutes, see Raymond C. O'Brien & Michael T. Flannery, *The Pending Gauntlet to Free Exercise: Mandating That Clergy Report Child Abuse*, 25 LOY. L.A. L. REV. 1, 18-20, n.106 (1991).

15. See, e.g., *Boy's Story Investigated*, SAN DIEGO UNION TRIB., Oct. 25, 1992 (offering opinion that child abuse reporting laws trigger "knee-jerk" reactions to report any hint of abuse or impropriety); Holland, *supra* note 13, at A3 (referring to a "therapist-induced hysteria about child abuse"); Mark Sauer, *'Scared Silent' Detractors Are Speaking Out*, SAN DIEGO UNION TRIB., Sept. 4, 1992, at C1 (discussing the media's exaggeration and perpetuation of the myths surrounding the issue of child abuse); Sauer & Okerblom, *supra* note 13, at 30 (discussing various cases involving alleged false accusations, which some have called a "national child-abuse conspiracy"); Anthony Shaw, *Don't Be So Sure It's Child Abuse: Accidental Injuries Can Appear to Be Caused By Abuse*, MED. ECON., Mar. 8, 1993 at 79. (asserting that misconceptions about child abuse often results in false accusations); Linell Smith, *Does the Media Blow Up Reports of Child Abuse?*, ST. LOUIS POST-DISPATCH, Oct. 6, 1993, at 4F (quoting Sandra Skolnik, executive director of the Maryland Committee for Children, who states: "A lot of the apprehension about child sexual abuse comes from the media's excessive rather than reasoned approach."). But see Ros Davidson, *LA Pioneers Radical Approach to Child Abuse*, HERALD, Mar. 8, 1994, at 17 (refuting current "trend" that describes child abuse statistics as exaggerated). Some states have taken measures to cut down the number of "frivolous" reports which tend to generate misconception about the accuracy of child abuse statistics. E.g., Randy Burton, *Don't Deter Abuse Reporting*, USA TODAY, Sept. 1, 1993, at 10A (referring to measures in Texas); Stein, *supra* note 13, at N1 (referring to measures in Illinois).

16. Munchausen Syndrome by Proxy was first identified in 1977 by Roy Meadow.

This article demonstrates that the recently recognized diagnosis of Munchausen Syndrome by Proxy broadens the scope of abuse. Consequently, cases that normally would be "weeded out" in the course of identifying overzealous reporters may, in fact, become an exclusive subcategory of child abuse.

Child abuse necessarily incorporates medical and legal definitions and standards that are not always apparent.¹⁷ As a simple example, a child's broken arm may be medically apparent, but it will not be legally relevant unless clear and convincing evidence shows the injury was caused by inappropriate parental behavior. Conversely, a child cannot legally be identified as an abused or neglected child without some indicia of relevant medical evidence qualifying the child as such. Congruously, if the scope of child abuse is to be broadened by evidence of Munchausen Syndrome by Proxy, then such evidence must be medically and legally relevant in relation to the child.

Part I of this article will introduce Munchausen Syndrome by Proxy as a medical phenomenon that has become identifiable only in the past twenty years. As the diagnosis of Munchausen Syndrome by Proxy becomes better understood, the medical profession will be forced to qualify the diagnosis in terms of its legal consequences. Similarly, the legal field will be forced to define the scope of child abuse in a way that will allow the medical profession to identify Munchausen Syndrome by Proxy as a qualified diagnosis within the scope of child abuse.

Part II of this article will demonstrate that Munchausen Syndrome by Proxy is sufficiently medically identifiable to warrant legal consideration within the parameters of commonly accepted definitions of child abuse. Part II will identify and

See Roy Meadow, *Munchausen Syndrome by Proxy: The Hinterland of Child Abuse*, 2 LANCET 343, 343-45 (1977) [hereinafter Meadow, *Hinterland*]. By 1992, there were more than 200 published cases of Munchausen Syndrome by Proxy. See Jon Jureidini, *Obstetric Factitious Disorder and Munchausen Syndrome by Proxy*, 181 J. NERV. & MENT. DISEASE 135, 135 (1993).

17. For a discussion of how medical diagnosis and documentation is crucial to dispositions within the legal forum, see Howard Dubowitz & Donald C. Bross, *The Pediatrician's Documentation of Child Maltreatment*, 146 AM. J. DISEASES CHILDREN 596, 596 (1992) ("The physician's assessment is a key component of the overall evaluation and it lends substantial weight to the adjudication and intervention by public agencies that are mandated to protect children.").

describe not only the victims of Munchausen Syndrome by Proxy, but also the perpetrators and professionals who have dealt with this phenomenon and have struggled to understand it. Each of the various professional fields involved has a unique method of identifying and dealing with the disease. The subjective experiences of professionals present baffling yet reasonable explanations for what is only superficially understood in the mid-1990s. However, a comprehensive understanding of Munchausen Syndrome by Proxy may begin to be revealed through a combined understanding of the people and professionals that are affected by its mystery. Only through a more comprehensive and unified understanding of its cause will the medical and legal fields be able to deal bilaterally with its effects. Today, however, both the medical and legal fields' understanding of and response to Munchausen Syndrome by Proxy is disjointed because of the different way in which each field is affected. Consequently, the medical and legal fields are forced to respond to Munchausen Syndrome by Proxy in a way that does not supplement the other's characterization of or response to the disease.

Once Munchausen Syndrome by Proxy is medically defined, understood, and subsequently identified and treated, the legal field must respond to the phenomenon in terms of its relationship to the family and society's acceptance of how to deal with the injured children left behind. In response then, the legal field is faced with a medical diagnosis that may or may not qualify as "abuse" within the scope of the commonly accepted definition. Equally troublesome is the fact that without a clearer or broader definition of abuse (such as a medically accepted definition of Munchausen Syndrome by Proxy), the medical field is limited in terms of defining the disease. Therefore, the law is also limited in its response to the effects of abuse. This circuitous dilemma will be explained in Part III of this article.

Additionally, both the medical and legal professions must struggle to identify, explain, treat, and respond to the disease within their own limitations. Part IV of this article will discuss the hurdles that each field must overcome in dealing with Munchausen Syndrome by Proxy. Part IV will also address the interdependence of each field's definitions in responding to the disease as both a medical and a legal entity.

In conclusion, this article explains that the dichotomy between the medical and legal professions which exists in defining Munchausen Syndrome by Proxy calls for a unified response by both fields. Munchausen Syndrome by Proxy cannot be addressed comprehensively without first having an inter-professional understanding of its definition, causes, and consequences.

II. MUNCHAUSEN SYNDROME BY PROXY AS A MEDICAL ENTITY

Munchausen Syndrome by Proxy was first clinically identified and described in 1977 by Roy Meadow, and the disorder was named after Hieronymus Karl Friedrich Freiherr von Munchausen, a man infamous for telling tall tales of adventure.¹⁸ It has also been referred to as "Polle Syndrome," although some commentators have concluded that this title is inappropriate.¹⁹

18. HERBERT A. SCHREIER & JUDITH A. LIBOW, HURTING FOR LOVE: MUNCHAUSEN BY PROXY SYNDROME 6-7 (1993); Meadow, *Hinterland*, *supra* note 16, at 343-45 (1977). A number of courts have often referred to the term "Munchausen," even prior to the identification of the syndrome described in this article, within the context of qualifying a witness' or defendant's credibility. Testimony with a bend toward the unreasonable has been described as "a Baron Munchausen tale." *See, e.g., Baker v. Reid*, 482 F. Supp. 470, 473 (S.D.N.Y. 1979).

19. *See* Roy Meadow & Thomas Lennert, *Munchausen by Proxy or Polle Syndrome: Which Term Is Correct?*, 74 PEDIATRICS 554, 554-56 (1984). "Burman and Stevens said that the real Baron von Munchausen had had a second marriage in 1794 and that his wife had given birth to Polle who died one year later. Therefore the term Polle Syndrome could be applied to a child of a person with Munchausen Syndrome." *Id.* at 554 (citation omitted). Other commentators have equated the phenomena. *See, e.g.,* Gary D. Clark et al., *Munchausen's Syndrome by Proxy (Child Abuse) Presenting as Apparent Autoerythrocyte Sensitization Syndrome: An Unusual Presentation of Polle Syndrome*, 74 PEDIATRICS 1100, 1100-02 (1984) (describing a case study of a child whose mother was stabbing the child's injection sites with hypodermic needles, causing unexplained bleeding as well as feeding the child epsom salt solutions); C.M. Verity et al., *Polle Syndrome: Children of Munchausen*, 2 BR. MED. J. 422, 422-23 (1979) (describing a case report of a mother who fabricated diabetic symptoms in her daughter and various illnesses in her son). Factually, however, Meadow and Lennert claim to have disproved this history and therefore conclude that the term is inappropriately ascribed to Munchausen Syndrome by Proxy. *See* Meadow & Lennert, *supra*, at 556; *see also* Vincent L. Guandolo, *Munchausen Syndrome by Proxy: An Outpatient Challenge*, 75 PEDIATRICS 526, 526 (1985). However, one must draw a distinction between the historically inaccurate definition of Polle Syndrome, which assigns "Munchausen Syndrome by Proxy" to a child of a person with Munchausen Syndrome, and the actual definition of Munchausen Syndrome by Proxy. The former definition is also inaccurate because a child of someone suffering from Munchausen Syndrome is not necessarily a child who is a victim of Munchausen Syndrome by Proxy. The two are only the same when a parent suffering from Munchau-

Munchausen Syndrome by Proxy is a harmful (sometimes lethal)²⁰ form of behavior that can often go unrecognized for months or even years.²¹ Typically, the disorder is perpetrated by a parent—usually a mother—who factitiously induces illnesses or symptoms in a child by fabricating evidence. The fabricated evidence usually results in numerous and extensive diagnostic procedures that in themselves can often harm the child.²²

sen Syndrome (inflicting fictitious symptoms on oneself) induces fictitious symptoms his or her child. Therefore, even if the term "Polle Syndrome" were historically correct, it would not necessarily be equated with Munchausen Syndrome by Proxy.

20. In Rosenberg's study of 117 victims of Munchausen Syndrome by Proxy, 10 of the victims died. Donna A. Rosenberg, *Web of Deceit: A Literature Review of Munchausen Syndrome by Proxy*, 11 CHILD ABUSE & NEGLECT 547, 547-63 (1987). Additionally, 10 siblings of those victims subsequently died under suspicious circumstances. See Tona L. McGuire & Kenneth W. Feldman, *Psychologic Morbidity of Children Subjected to Munchausen Syndrome by Proxy*, 83 PEDIATRICS 289-91, 291 (1989); Rosenberg, *supra* at 547-63. These figures conform with those generated in a 1991 survey by Schreier and Libow. SCHREIER & LIBOW, *supra* note 18, at 6 n.2. In a separate study conducted in 1990, 31% of the children studied died. Randall Alexander et al. *Serial Munchausen Syndrome by Proxy*, 86 PEDIATRICS 581, 584 (Oct. 1990).

21. In one of the case studies described by Meadow, the child patient was forced to undergo numerous surgical and radiological procedures until Munchausen Syndrome by Proxy was finally identified six years after the symptoms appeared. See Meadow, *Hinterland*, *supra* note 16, at 343. During the six years, the child had undergone the following treatment:

Twelve hospital admissions, [seven] major X-ray procedures (including intravenous urograms, cystograms, barium enema, vaginogram, and urethrogram), [six] examinations under anaesthetic, [five] cystoscopies, unpleasant treatment with toxic drugs and eight antibiotics, catheterizations, vaginal pessaries, and bactericidal, fungicidal, and oestrogen creams; the laboratories had cultured her urine more than 150 times and had done many other tests; sixteen consultants had been involved in her care.

Id. at 344.

In a study conducted by Schreier and Libow, it took more than six months to diagnose Munchausen Syndrome by Proxy in 33% of the cases studied. See SCHREIER & LIBOW, *supra* note 18, at 65. In 19% of the cases, it took more than a year to make the diagnosis. See *id.* Rosenberg's study revealed that diagnosis time ranged from just days to 20 years. See Rosenberg, *supra* note 20, at 547.

22. "Although initial reports of symptoms may be false in [Munchausen Syndrome by Proxy], victims may incur secondary true illnesses or suffer as a result of extensive and invasive investigations and interventions." Basil J. Zitelli et al., *Munchausen's Syndrome by Proxy and Its Professional Participants*, 141 AM. J. DISEASES CHILDREN 1099, 1100 (1987) (citing Roy Meadow, *Munchausen Syndrome by Proxy*, 57 ARCHIVES OF DISEASES OF CHILDREN 92, 92-98 (1982)).

In Meadow's case study, the physicians were confronted with unexplainable symptoms in a six-year-old child, evidenced for the most part by abnormal levels of blood in the child's urine.²³ Initially, the physicians were puzzled, but after many diagnostic tests and invasive procedures, the physicians observed that the mother's behavior and disposition were uncommonly similar to that of a mother involved in another case study.²⁴ Suspicions escalated when medical personnel discovered that the child experienced abnormal blood levels only when she was left unsupervised with the mother.²⁵ Consequently, physicians controlled and strictly supervised all testing for the next three days. These tests produced normal results. On the fourth day, the physicians relaxed the structure of the tests, and they allowed the mother to draw the child's specimen of urine or to be left unsupervised with a specimen obtained by the nurse. These results were abnormal. During a seven-day period, fifty-seven specimens were drawn. The only twelve specimens that were abnormal were those drawn by or left in the presence of the mother. Eventually, medical personnel persuaded the mother to supply a urine specimen, and the police forensic unit determined that the mother either had been supplying her own urine in place of the child's or contaminating the child's urine with her menstrual discharge.²⁶ The mother was referred to outpatient therapy, and it was later discovered that she had an extensive medical history throughout which "she had been suspected of altering urine specimens, altering temperature charts, and heating a thermometer in a cup of tea."²⁷

Meadow's second case study, to which the mother of the first study was compared, revealed a six-week-old child with high

23. For a brief discussion by Roy Meadow regarding the dynamics of the syndrome, see Roy Meadow, *Foreword* to SCHREIER & LIBOW, *supra* note 18, at vii-x [hereinafter Meadow, *Foreword*].

24. In Meadow's study, the mothers in both cases were quite cooperative with medical staff and incessantly stayed by the child's side, feeling quite at ease and comfortable during long hospital stays. The mothers' appreciation and pleasant disposition spurred the medical team to try even harder. See Meadow, *Hinterland*, *supra* note 18, at 343-44. However, the mothers also seemed less concerned with the origins of the symptoms than did the doctors. *Id.* at 343.

25. *Id.*

26. *Id.* at 343-44.

27. *Id.*

sodium levels.²⁸ After twelve months and many intrusive medical procedures, doctors suspected Munchausen Syndrome by Proxy when they discovered that the child's blood levels were abnormal only when the infant was at home with the mother. After controlled testing, it was determined that the mother, a nurse with experience in gastric tube feeding, was administering sodium to the child. While social service agencies were coordinating plans with medical staff, the child was again admitted to the hospital and subsequently died. The mother attempted suicide and, like the mother in the first case study, had a suspected history of mental illness and interference with her own medical treatment.²⁹

Munchausen Syndrome by Proxy is typically categorized by four identifiable elements: (1) the child's illness is simulated or produced by a parent or someone acting in a parental role; (2) the parent repeatedly requests medical evaluation and care of the child; (3) the perpetrator denies any knowledge of the etiology; and (4) the symptoms quickly cease when the child and the perpetrator are separated.³⁰ Although the fabricated symp-

28. *Id.* at 344.

29. *Id.* at 343-44.

30. Susan O. Mercer & Jeanette D. Perdue, *Munchausen Syndrome by Proxy: Social Work's Role*, 38 SOC. WORK 74, 74-75 (1993); Richard E. Sofinowski & Patricia M. Butler, *Munchausen Syndrome by Proxy: A Review*, 87 J. TEX. MED. 66, 66 (1991). These elements are the most commonly indicative factors of the syndrome, but they are not exclusive. Other diagnostic indicators are the following:

1. Persistent or recurrent illnesses for which a cause cannot be found[;]
2. Discrepancies between the history and clinical findings[;]
3. Symptoms and signs that do not occur when a child is separated from the mother[;]
4. Unusual symptoms, signs, or medical course that do not make clinical sense[;]
5. A differential diagnosis consisting of disorders less common than Munchausen [S]yndrome by [P]roxy[;]
6. Persistent failure of a child to tolerate or respond to medical therapy[;]
7. A parent who appears to be less concerned than the physician and who may even spend time comforting the hospital staff[;]
8. Repeated hospitalizations and vigorous medical evaluations of mother or child without a definitive medical diagnosis[;]
9. A parent who is constantly at the child's bedside, excessively praises the staff, becomes overly attached to the staff, or becomes highly involved in the care of other patients[;]

toms take many forms, some symptoms have been commonly documented.³¹ The most common symptoms described in the

10. A parent who welcomes medical tests of the child, even when the procedures are painful to the child.

Mercer & Perdue, *supra* at 75 (reprinted from Jerry G. Jones et al., *Munchausen Syndrome by Proxy*, 10 CHILD ABUSE & NEGLECT 33, 33-40 (1986)); see also SCHREIER & LIBOW, *supra* note 16, at 203 (enumerating similar signals of Munchausen Syndrome by Proxy). Some commentators note that many of the psychosomatic, pathological behaviors demonstrated by Munchausen Syndrome by Proxy mothers are ironically similar to the adaptive behaviors demonstrated by and expected of mothers caring for children with actual chronic illnesses. See Penelope Krener & Raymond Adelman, *Parent Salvage and Parent Sabotage in the Care of Chronically Ill Children*, 142 AM. J. DISEASES CHILDREN 945, 946 (1988).

31. In 1989, Meadow designed a comparative list of false signs and causes of fabricated illnesses. See Roy Meadow, *ABC of Child Abuse Munchausen Syndrome by Proxy*, 299 BRIT. MED. J. 248, 248-50 (1989). Meadow offers the following as common indicators of fabricated illnesses with their causes:

<i>False Signs</i>	<i>Cause</i>
Seizures, apnea, drowsiness	Poisons, suffocation, pressure on carotid sinus
Bleeding	Mother's blood (particularly vaginal tampon), raw meat, coloring agents added to sample or smeared on child
Fever	Warming thermometer, altering temperature chart, injections of contaminated material into child's veins, repetitive injections of antigenic matter
Diarrhea	Laxatives
Vomiting	Salt or emetic poisoning, mechanically induced
Hypertension	Altering blood pressure chart or instructions for size of cuff for blood pressure estimation
Rashes	Scratching the skin to cause blisters, using caustics and dyes
Renal Stone	Addition of stone to child's urine to which blood has previously been added
Failure to thrive and thinness	Withholding food, or, if the child is in the hospital, the parent can interfere with treatment and even suck back stomach contents through nasogastric tube

minimal studies available are apnea,³² seizure disorders,³³ intractable vomiting,³⁴ diarrhea,³⁵ septicemia,³⁶ cystic fibrosis,³⁷ hypoglycemia,³⁸ and gastrointestinal bleeding.³⁹ Some of the common abuses perpetrated by the parent include insulin injections,⁴⁰ ipecac poisoning,⁴¹ administration of laxatives,⁴² and many other forms of deception through physical

32. See Carol L. Rosen et al., *Two Siblings With Recurrent Cardiorespiratory Arrest: Munchausen Syndrome by Proxy or Child Abuse?*, 71 PEDIATRICS 715, 715-20 (1983).

33. See Roy Meadow, *Fictitious Epilepsy*, 2 LANCET 25, 25-28 (1984); Roy Meadow, *Munchausen Syndrome by Proxy*, 57 ARCHIVES OF DISEASES OF CHILDREN 92, 92-98 (1982) [hereinafter Meadow (1982)].

34. See J.L. Sutphen & Frank T. Saulsbury, *Intentional Ipecac Poisoning: Munchausen Syndrome by Proxy*, 82 PEDIATRICS 453, 453-55 (1988); Deborah A. Lee, *Munchausen Syndrome by Proxy in Twins*, 54 ARCHIVES OF DISEASES OF CHILDREN 646, 646-47 (1979). For a description of a case study involving intractable vomiting symptomatology, see McGuire & Feldman, *supra* note 20, at 290 (Case 2).

35. Mark A. Epstein et al., *Munchausen Syndrome by Proxy: Considerations in Diagnosis and Confirmation by Video Surveillance*, 80 PEDIATRICS 220, 220-24 (1987).

36. See Thomas E. Liston et al., *Polymicrobial Bacteremia Due to Polle Syndrome: The Child Abuse Variant of Munchausen by Proxy*, 72 PEDIATRICS 211, 211-13 (1983).

37. See David M. Orenstein & Abbey L. Wasserman, *Munchausen Syndrome by Proxy Simulating Cystic Fibrosis*, 78 PEDIATRICS 621, 621-24 (1986).

38. See George Grunberger et al., *Factitious Hypoglycemia Due to Surreptitious Administration of Insulin*, 108 ANNALS INT. MED. 252, 252-57 (1988); W.A. Bauman & R.S. Yalow, *Child Abuse: Parental Insulin Administration*, 99 J. PEDIATRICS 588, 588-91 (1981).

39. Jeffrey J. Malatak et al., *Munchausen Syndrome by Proxy: A New Complication of Central Venous Catheterization*, 75 PEDIATRICS 523, 523-25 (1985).

40. See, e.g., Bauman & Yalow, *supra* note 38, at 588-91.

The most commonly known case of Munchausen Syndrome by Proxy involving insulin injection is the case of Beverly Allitt, a United Kingdom nurse serving 13 life sentences for killing four children and injuring nine others who were under her care between February and May 1991. Clare Thompson, *Preventing Munchausen's-By-Proxy; Munchausen Syndrome by Proxy*, 343 LANCET 471 (1994). Allitt also killed her victims by suffocation or by potassium and oxygen injections. *Id.* Allitt suffered from Munchausen Syndrome and admitted herself 24 times for factitious or self-inflicted injuries at the hospital where she was employed and carried out her crimes on the children. Eugene Robinson, *A Dose of Death: England Probes Hiring of Nurse Who Killed 4*, WASH. POST, May 19, 1993, at B1.

41. See, e.g., H. Juhling McClung et al., *Intentional Ipecac Poisoning in Children*, 142 AM. J. DISEASES CHILDREN 637, 637-39 (1988) (demonstrating the potential for acute and chronic abuse of ipecac); Sutphen & Saulsbury, *supra* note 34, at 453-56 (suggesting that child abuse by ipecac poisoning may be underestimated). *But see* Toby Litovitz, *In Defense of Retaining Ipecac Syrup as an Over-The-Counter Drug*, 82 PEDIATRICS 514, 514-15 (1988) (opposing the return of ipecac to prescription status due to its inherent benefits in treating poison victims).

42. For a description of a case study in which the mother administered laxatives to the child to induce diarrhea, see McGuire & Feldman, *supra* note 20, at 289-90

manipulation of external sources.⁴³ Studies of the various symptoms and strategies have had much to offer medical professionals in terms of recognizing common, as well as uncommon,⁴⁴ signs of the disease.⁴⁵

Almost two decades have passed since Munchausen Syndrome by Proxy was first identified.⁴⁶ A recent and growing understanding of the disease has led to increased numbers of reports and diagnoses each year.⁴⁷ In a 1988 survey of sixteen hospi-

(Case 1).

43. See Karen A. Crouse, *Munchausen Syndrome by Proxy: Recognizing the Victim*, 18 PEDIATRIC NURSING 249, 249 (1992) (mother contaminated child's stool specimens with her own menstrual blood); Malatak, *supra* note 39, at 523-25 (mother used catheter to withdraw blood from child and feigned blood loss).

44. The case studies that have been conducted help researchers become aware of the great lengths to which perpetrators will go to orchestrate their deception. One study describes a mother who contacted patients listed in records from the Cystic Fibrosis Foundation and requested expectorate samples under the auspices of conducting research. See Orenstein & Wasserman, *supra* note 37, at 621-24. Other bizarre cases involve a mother injecting feces under the skin of the child to cause infection. Susan Cahill, *Patients Who Are Just Faking*, WASH. POST, Apr. 5, 1994, at Z18. A nurse who suffered from Munchausen Syndrome "drew her own blood and inserted it, along with egg white, into her bladder to mimic the symptoms of kidney failure." *Id.* She eventually convinced doctors to remove her kidney. *Id.*

45. Doctors should be mindful of the pediatric patient who is discharged against medical advice (AMA). One study concludes that Munchausen Syndrome by Proxy was suspected in 64% of the AMA cases reviewed and 8% of cases that were transferred to another hospital. See Sushma Jani et al., *Munchausen Syndrome by Proxy*, 22 INT'L J. PSYCHIAT. MED. 343, 348-49 (1992).

46. See Meadow, *Hinterland*, *supra* note 16, at 343.

47. See McGuire & Feldman, *supra* note 20, at 289. As of February 1994, it was estimated that 400 to 500 cases of Munchausen Syndrome by Proxy were diagnosed each year. See Nancy Wartik, *Fatal Attention*, REDBOOK, Feb. 1994, at 64. One cause for the increased awareness of Munchausen Syndrome by Proxy may be the continuing advances in modern medicine. See Meadow, *Foreword*, *supra* note 23, at ix. However, some commentators suggest that as a consequence of the improvements in detection of the disease, there may be a pattern of overdiagnosis. See Krener & Adelman, *supra* note 30, at 946. Overdiagnosis, combined with the availability of advanced medical procedures, results in doctors making hasty decisions to perform unnecessary procedures rather than taking time to consult with the mother. See Meadow, *Foreword*, *supra* note 23, at ix. Nevertheless, it is still difficult to ascertain the prevalence of the disorder accurately. Schreier and Libow offer three factors, aside from inadequate data, that may account for the difficulty in even generalizing about the disorder:

First, case definitions are imprecise and not sensitive, especially for the milder forms of the disorder and those in which older children are involved. Second, it is likely that legal and monetary disincentives hinder reporting. . . . Third, none of the studies have a defined population base

tals from fourteen states, sixty-eight suspected cases were reported with thirty-two diagnosed cases in the preceding three to five years.⁴⁸ Much of the published literature addressing Munchausen Syndrome by Proxy concerns the more sensationalized and unusual cases. However, there are innumerable cases in hospitals and courtrooms throughout the world that are discovered and treated; unfortunately, even more go unrecognized and unreported.⁴⁹ The fact that society accepts Munchausen Syndrome by Proxy as a rare disorder in spite of the data indicating otherwise leads to under-recognition and consequently under-reporting by both fields.⁵⁰ Ultimately, this relationship increases the risk of harm to children who fall victim to Munchausen Syndrome by Proxy in a less sensationalized manner.⁵¹ These less sensationalized and less clearly abusive cases inhibit courts from closing the gap between the medical and legal acceptance of the disorder.

Clearly identifying, understanding and defining Munchausen Syndrome by Proxy as "child abuse" has been problematic from the identification of the disorder. Even Meadow questions the distinction between the diagnosis and abuse, concluding that the two children in his original case study were abused. However, Meadow is hesitant to classify the cases as "non-accidental injuries,"⁵² a classification commonly accepted to describe more prevalent forms of child abuse.⁵³ Regardless of its accepted

and suffer from low physician response rates, making generalization difficult.

SCHREIER & LIBOW, *supra* note 18, at 63.

48. See Mercer & Perdue, *supra* note 30, at 76-77.

49. See SCHREIER & LIBOW, *supra* note 18, at 67-68.

50. One study conducted of one hospital's pediatric nursing staff revealed that 55% of the nursing staff had never heard of Munchausen Syndrome by Proxy and 70% felt that they would not be prepared to confront the disease if they ever encountered it. See Cahill, *supra* note 44, at Z18.

51. See SCHREIER & LIBOW, *supra* note 18, at 68.

52. Other commentators also draw a distinction between Munchausen Syndrome by Proxy and certain "accidental injuries" when there is no presentation of a factitious history. See Zitelli et al., *supra* note 22, at 1100. "The history is often key to interpreting the current situation, particularly in neglectful situations and Munchausen [S]yndrome by [P]roxy, where the pattern of incidents is crucial." Dubowitz & Bross, *supra* note 17, at 597.

53. See Meadow, *Hinterland*, *supra* note 16, at 345. Meadow initially excluded poisoning as a form of Munchausen Syndrome by Proxy without other fabricated acts by the parent. See Meadow (1982), *supra* note 33, at 92-98; Zitelli et al., *supra* note

definition, Meadow further posits the fundamental question first raised⁵⁴ in 1951—why has Munchausen Syndrome by Proxy only recently been recorded in medical literature?⁵⁵ In 1977, Meadow followed up the question by asking: “Is it because that degree of falsification is very rare or because it is unrecognized?”⁵⁶ To answer these questions, one must first fully understand the dynamics of the disorder in relation to those participants it so mysteriously affects.

III. THE PARTIES INVOLVED IN MUNCHAUSEN SYNDROME BY PROXY

A. *The Mothers*

In almost all cases of Munchausen Syndrome by Proxy, the perpetrator is a female figure, either the natural mother or the adoptive mother.⁵⁷ Profiles show that perpetrating mothers are usually between the ages of twenty and twenty-five,⁵⁸ and they typically have a history of mental health and medical problems.⁵⁹ Munchausen Syndrome by Proxy mothers are typically

22, at 1100 (agreeing that poisoning, when accompanied by another factitious history, should qualify as Munchausen Syndrome by Proxy). Meadow later qualified poisoning as one form. See Roy Meadow, *Management of Munchausen Syndrome by Proxy*, 60 ARCHIVES OF DISEASES OF CHILDREN 385, 385-93 (1985).

54. See R. Asher, *Munchausen's Syndrome*, 1 LANCET 339, 339 (1951).

55. See Meadow, *Hinterland*, *supra* note 16, at 345.

56. *Id.*

57. See Mercer & Perdue, *supra* note 30, at 77.

58. The youngest documented mother perpetrator of Munchausen Syndrome by Proxy is a woman who had her first child at age 13. See SCHREIER & LIBOW, *supra* note 18, at 8. An independent study performed in 1987 revealed that “41% of 186 patients for whom data was available had developed the disorder by age 18.” *Id.* at 8 n.9 (citing C.A. Raymond, *Munchausen's May Occur in Younger Persons*, 257 J. AM. MED. ASS'N 3332, 3332 (1987)).

59. Alexander et al. *supra* note 20, at 581-85 (stating that 80% of the mothers studied had a history of psychiatric treatment prior to diagnosis); Mercer & Perdue, *supra* note 30, at 77; Zitelli et al., *supra* note 22, at 1101.

Currently, there is no standard profile of a Munchausen Syndrome by Proxy mother; however, Schreier and Libow offer conclusory remarks on what seem to be common patterns of the studied mothers. They note:

We do feel an impressive consistency in the patterns of these mothers' limited store of information (with the exception of medical knowledge), poor abstract conceptual ability, superficial social skills, and outgoing behavior. This is coupled with a rigid, denying defensive style masking

cooperative with medical staff, overzealously involved in the child's care, and medically knowledgeable.⁶⁰ In a surprising number of cases, the mothers have extensive backgrounds in nursing or other medical fields.⁶¹ Most mothers seem to thrive in the hospital environment, yet they rarely express much concern over the child's illness.⁶² In fact, many mothers spend an exorbitant amount of time at the hospital comforting other mothers and socializing within similar circles of the hospital rather than spending time with their child.⁶³ Despite the lack of attention to the child, many mothers often make it a point to express that they are the only ones to whom the child positively responds. Furthermore, the mother often claims to be able to

an underlying rebelliousness, emotional immaturity, self-centeredness, lack of social conformity, and intense passive resentment. This is the profile of a patient who is likely to be very resistive to psychotherapy and therefore very challenging to treat.

SCHREIER & LIBOW, *supra* note 18, at 185.

60. See, e.g., Mercer & Perdue, *supra* note 30, at 77. The mother's overzealous nature is a significant characteristic for hospital staff in distinguishing between Munchausen Syndrome by Proxy mothers and other mothers. See Zitelli et al., *supra* note 22, at 1101.

61. Judith A. Libow & Herbert A. Schreier, *Three Forms of Factitious Illness in Children: When is It Munchausen Syndrome by Proxy?*, 56 AM. J. ORTHOPSYCHIATRY 602, 606 (1986); Alexander et al., *supra* note 20, at 584; Zitelli et al., *supra* note 22, at 1101; see also Crouse, *supra* note 43, at 250.

62. See, e.g., Crouse, *supra* note 43, at 250; see also Zitelli et al., *supra* note 22, at 1101. The parent's reaction to the child's symptoms is an important factor for doctors in recognizing Munchausen Syndrome by Proxy. Doctors must be mindful of the parent's reaction in distinguishing between mothers perpetrating Munchausen Syndrome by Proxy and those who would be termed "persistent parents." For a complete discussion of "persistent parents" and how they relate to Munchausen Syndrome by Proxy, see William W. Waring, *The Persistent Parent*, 146 AM. J. DISEASES CHILDREN 753, 753-56 (1992), in which the author asserts that doctors must make the following two diagnoses in treating children: "(1) What is the matter with the patient? and (2) Why is the child being brought for care at this moment?" *Id.* at 753. The congruence of these diagnoses will guide the doctor in determining whether Munchausen Syndrome by Proxy is the appropriate diagnosis. Munchausen Syndrome by Proxy will usually exist "when there is no primary organic disease, the parent is persistent, and falsification exists." *Id.* at 756. Distinguishing the two diagnoses is critical because a persistent parent and a person diagnosed with Munchausen Syndrome by Proxy are not necessarily the same; each may require different treatment. Schreier and Libow describe a similar distinction between Munchausen Syndrome by Proxy parents and overly anxious parents. See SCHREIER & LIBOW, *supra* note 18, at 14-15.

63. See SCHREIER & LIBOW, *supra* note 18, at 17-18. The mother often behaves similarly at the child's funeral. See *id.* at 18.

predict when the child will improve. These improvements happen to occur only in her absence.⁶⁴

In many cases, the mother, who often suffers from Munchausen Syndrome herself,⁶⁵ either inflicts the same injuries or harm upon herself or complains of similar symptoms as those designated to the child.⁶⁶ Conversely, many mothers inflict symptoms similar to those historically suffered by themselves or other family members.⁶⁷ While the mothers appear to care and dote on the child, they are often insecure and dependent. This emotional state seemingly stems from an abusive childhood⁶⁸ combined with an unstable relationship with the child's natural father.⁶⁹ The behavioral tendencies of mothers often result from their desire to avoid the home dynamics and interact with doctors, social workers and other parents, thus placing themselves in a nurturing environment that may be a substitute for the intimacy expected between a child's parents.⁷⁰ It is unclear to what extent, if any, the familial and social dynamics of the

64. See Rosenberg, *supra* note 20, at 547-63; Zitelli et al., *supra* note 22, at 1101.

65. "Somewhere between one tenth and one quarter of [Munchausen Syndrome by Proxy] mothers are believed to also suffer from Munchausen Syndrome." SCHREIER & LIBOW, *supra* note 18, at 29-30.

66. Alexander et al., *supra* note 20, at 584 (stating that 80% of mothers studied suffered from Munchausen Syndrome as well); Crouse, *supra* note 43, at 250; Meadow (1982), *supra* note 33, at 92-98; Zitelli et al., *supra* note 22, at 1101.

67. See SCHREIER & LIBOW, *supra* note 18, at 18.

68. It is suggested by some commentators that the abusive histories of Munchausen Syndrome by Proxy mothers are often more fabricated than true. See, e.g., Rosenberg, *supra* note 20, at 556. Schreier and Libow state that "early neglect and loss, resulting in feeling unimportant and ignored, seem to be more common themes than active abuse in these mothers' lives." SCHREIER & LIBOW, *supra* note 18, at 20. One theory suggests that the Munchausen Syndrome by Proxy mother is acting out her "unacceptable" needs and desire for autonomy yet holding true to society's expectations for the woman to fulfill her role as a devoted caretaker. *Id.* at 104-09. Any abuse that is verified in the mothers' histories, however, is more often psychological than physical or sexual. *Id.* at 93.

69. See *supra* note 20; Mercer & Perdue, *supra* note 30, at 78.

70. "[I]t has not been [the mother's] fixation on a particular physician, nurse, or other person, but [her] need for escape from home or an unsupportive husband, or just [her] own general insecurity, that has caused [her] to make [her] child ill in order to escape into the hospital environment." SCHREIER & LIBOW, *supra* note 18, at 85 n.2 (disagreeing with, but quoting from, communications with Roy Meadow); see also Crouse, *supra* note 43, at 250; Meadow, *Hinterland*, *supra* note 16, at 345 (citing S.B. Lansky & H.M. Erikson, *Prevention of Child Murder*, 13 J. AM. ACAD. CHILD PSYCHIATRY 691 (1974)); Mercer & Perdue, *supra* note 30, at 78; Zitelli et al., *supra* note 22, at 1101.

mother may be a cause for the behaviors typically observed in perpetrators of Munchausen Syndrome by Proxy.⁷¹ Nevertheless, the variable dynamics certainly add to the problematic interactions between perpetrators and professionals.⁷² This only exaggerates the difficulty in assessing what is best for the child.⁷³

71. It is unlikely that there is one single cause for Munchausen Syndrome by Proxy. Meadow (1982), *supra* note 33, at 92-98. However, it is clear from the many similarities uncovered in the many case studies that psychosocial histories play an important role in the doctor's ability to diagnose or even suspect Munchausen Syndrome by Proxy. For example, Schreier and Libow advocate that "[Munchausen Syndrome by Proxy] behavior is rooted in the young girl's need for but lack of recognition from others in her formative years, and is undoubtedly aided by individual constitutional givens." SCHREIER & LIBOW, *supra* note 18, at xv. See generally *id.* at 93-97 (comparing the relationship between the mother's historical paternal dynamics to her relationship with her physician). "It is noteworthy that the fathers of the child victims of [Munchausen Syndrome by Proxy] tend to mirror the fathers of the [Munchausen Syndrome by Proxy] mothers. . . ." *Id.* at 116.

The following are important areas to cover in the psychosocial history: [F]irst, the details of the family and household situation, the primary caretakers, the marital status, the employment status, the sleeping arrangements of the members of the family and household, and who feeds the child and who is responsible for toilet training and discipline.

Second, is there a history of maltreatment in the family? For example, have any siblings been reported to child protective services? Is there a history of violence between the spouses?

Third, are there stressors on the family, such as a housing problem, inadequate funds for food, problems in coping with a child's difficult behavior, the recent loss of a job, a divorce, or a death in the family?

Fourth, are there any alcohol or substance abuse problems in the family?

Fifth, what are the parents' coping strategies, supports, or current interventions? Are they involved in community groups?

And sixth, what is the caregiver's view of the child? Does the caregiver think that the child is easy or difficult to care for?

Dubowitz & Bross, *supra* note 17, at 598. These factors are pertinent to all cases of suspected child abuse, however, because of the unique circumstances surrounding Munchausen Syndrome by Proxy, many more particularized factors such as the numerous common indicators of the disorder could be added. See *infra* text accompanying notes 106-10.

If or when the dynamics of the disorder can be more clearly understood, they may play an important role in the decisions of judges and prosecutors involved in custody and criminal dispositions. See, e.g., SCHREIER & LIBOW, *supra* note 18, at 88-91 (describing a case in which the prosecutor reduced the charges against the perpetrating mother from murder to manslaughter once the dynamics of the disorder were understood).

72. See Zitelli et al., *supra* note 22, at 1101.

73. One study examining psychosomatic symptoms in the child differing from other studies involving active participation on the part of the parents suggests that some symptoms in children may stem from psychosocial factors surrounding non-phys-

Generally, commentators accept three classifications of perpetrators: (1) help seekers, (2) active inducers, and (3) doctor addicts.⁷⁴ Help seekers typically displace the distress surrounding their personal problems by reporting distressing symptoms for the child. In addition, help seekers often thrive on medical intervention and are receptive to counseling and professional interaction.⁷⁵ The classic active inducers are resistant to medical or provisional intervention and camouflage their psychiatric problems with overtly commendable parenting.⁷⁶ Doctor addicts more closely resemble active inducers, but they are so overly-obsessed with the child's illness that they demonstrate paranoid tendencies toward the treatment team.⁷⁷ All three classifications offer equally difficult problems in terms of identification and resolution of the disorder.⁷⁸

Additionally, some studies show an alarmingly high rate of recidivism involving siblings.⁷⁹ While it is difficult, if not im-

ical parental influences. See Anthony J. Richtsmeier & David B. Waters, *Somatic Symptoms as Family Myth*, 138 AM. J. DISEASES CHILDREN 855, 855-57 (1984); see also Anthony J. Richtsmeier, *Individual Interviews of Children With Unexplained Symptoms*, 139 AM. J. DISEASES CHILDREN 506, 506-08 (1985). The study is important for Munchausen Syndrome by Proxy because the authors stress that "[w]hen families unitedly reject the possibility of psychological influences on symptoms, diagnostic and therapeutic efforts can become problematic." Richtsmeier & Waters, *supra*, at 855. Another study reveals that historical psychosocial information is particularly important for doctors in diagnosing Munchausen Syndrome by Proxy because of the factitious histories reported by the perpetrator. Zitelli et al., *supra* note 22, at 1100.

74. SCHREIER & LIBOW, *supra* note 18, at 10; Libow & Schreier, *supra* note 61, at 606-07.

75. Libow & Schreier, *supra* note 61, at 606-07.

76. *Id.* The active inducers demonstrate behavior that may be especially troublesome to differentiate from "difficult" parents of chronically ill children. Parents of chronically ill children, without taking any actively abusive role, may unwittingly interfere with or interrupt their child's medical care through efforts to compensate for their own stress or to reassure themselves of their child's normal existence. See Krener & Adelman, *supra* note 30, at 946, 949-50.

77. Libow & Schreier, *supra* note 61, at 607.

78. In 1993, Schreier and Libow reevaluated the distinctions between the "inducers" and "noninducers" in terms of presentation of the cases. See SCHREIER & LIBOW, *supra* note 18, at 10-11. Curiously, almost all Munchausen Syndrome by Proxy mothers demonstrate an uncanny ability to remain calm during times when the child is most critically ill. *Id.* at 130 n.5.

79. See, e.g., Alexander et al., *supra* note 20, at 585 (discussing "serial Munchausen Syndrome by Proxy"); C.N. Bools, et al., *Co-morbidity Associated With Fabricated Illness (Munchausen Syndrome by Proxy)*, 67 ARCHIVES OF DISEASES OF CHILDREN 77, 77-79 (1992) (finding that 39% of siblings are victims of Munchausen Syndrome by

possible, to estimate accurately a recidivism rate among siblings of victims of Munchausen Syndrome by Proxy, some commentators estimate that the rate may be as high as thirty-three percent.⁸⁰ Other studies offer staggering statistics regarding the serial nature of the disorder. "[I]n cases of suffocation by mothers, [forty-eight percent] of the child victims had a sibling who died of supposed 'SIDS' (sudden infant death syndrome or crib death), which compares with [two percent] sibling death rate in what are felt to be true SIDS deaths."⁸¹ Early intervention in

Proxy).

80. See Alexander et al., *supra* note 20, at 585.

81. SCHREIER & LIBOW, *supra* note 18, at 28 n.29. Dr. Schreier appeared on the nationally broadcasted *Dateline NBC* and commented on the case of Tanya Reed, a woman who was convicted of child endangerment in Iowa and sentenced to ten years in prison for attempting to suffocate her son, Matthew. *Dateline NBC: In Harm's Way* (NBC television broadcast, March 29, 1994) (transcript available through Burrelle's Information Services). Reed was subsequently extradited to Texas where she was convicted of murdering her daughter, Morgan, and she was sentenced to 62 years in prison. *Id.* Morgan was originally thought to have died of SIDS. *Id.*

Most recently, investigators uncovered a remarkable case involving the death of five siblings, all of whom were thought to have died from SIDS, but who now are thought to be victims of Munchausen Syndrome by Proxy. See Ben Dobin, *Medical Journal Article Sent Prosecutor Sleuthing*, L.A. TIMES, Apr. 3, 1994, at A2; Terence Samuel, *Murder or Medical Mystery?*, PHILADELPHIA INQUIRER, Apr. 3, 1994, at A1. Between 1965 and 1971, the mother, Waneta Hoyt, allegedly murdered five of her children after demonstrating what now appears to be "classic" Munchausen Syndrome by Proxy behavior. Now, 23 years after the death of her fifth child and eight years after prosecutors became suspicious of the children's deaths, Waneta Hoyt faces prosecution for the murder of all five of her children. Samuel, *supra*, at A10.

The first child, Erik, was born in October 1964 and died less than four months later. James was born in June 1966, and Julie was born two years later. Julie lived for 48 days before allegedly choking on cereal. Just two weeks after Julie's death, James allegedly collapsed and died after eating breakfast, leaving Waneta Hoyt childless. None of the children's deaths were medically explained at the time. Samuel, *supra*, at A10.

In 1970, Waneta Hoyt gave birth to a fourth child, Molly, who was admitted to the hospital eight days after her birth. After two weeks in the hospital, Molly was discharged without a medical explanation for the apnea symptoms described by her mother. Dr. Alfred Steinschneider, a specialist in SIDS, became involved in the case and monitored Molly for 52 uneventful days in the hospital after another alleged apnea episode. She was then discharged to her mother and returned to the hospital for a third time two days later. After another 11 days in the hospital without a diagnosis, Molly was again discharged to Waneta Hoyt, only to return to the hospital the next day, allegedly suffering from two more apnea episodes. She was again discharged to her mother on an apnea monitor and subsequently died after another alleged episode while in the mother's care. Samuel, *supra*, at A10.

One year after Molly's death, Waneta Hoyt gave birth to her fifth child, Noah, who spent 33 quiet days under the care of Dr. Steinschneider. He was sent home to

the initial case of Munchausen Syndrome by Proxy within a family hinders accurate accounts of recidivism. As some commentators explain:

Any accurate recidivism estimate for the risk to siblings can only be obtained by studies of families in which there is at least one sibling in addition to a known child victim of [Munchausen Syndrome by Proxy] and there are no interventions to alter natural outcomes. Because intervention is likely to occur as a result of the known [Munchausen Syndrome by Proxy], subsequent recidivism rates may differ from the risk to siblings before the initial discovery. Thus, a precise estimate of the risk of serial [Munchausen Syndrome by Proxy] may not be possible.⁸²

While intervention is likely to dissuade further instances of abuse, legally confronting the mother prevents the collection of accurate recidivism statistics which are most helpful in proving risk to the siblings in remaining in the home.⁸³ Alexander,

his mother, but he returned to the hospital with two alleged apnea episodes in less than 24 hours. Noah spent another 34 unremarkable days in the hospital and was again discharged to Waneta Hoyt. The next day, Noah was readmitted for breathing difficulty and spent six more days in the hospital. On the day he was returned to his mother, Noah died. Only Waneta Hoyt witnessed the alleged apnea attacks of her five children. A sixth child, Jay, was adopted when he was three-weeks-old. He is now seventeen-years-old and is very close with his mother. Samuel, *supra*, at A10.

In March 1994, prosecutors were finally able to determine the identity of the family, known to legal authorities only as initials in medical literature. Until 1994, there were no suspicions raised by legal or medical authorities. When finally confronted by local authorities, Waneta Hoyt fully cooperated with the investigation and was described as "everybody's neighbor." Samuel, *supra*, at A10. Within five hours of beginning police questioning, Waneta Hoyt signed a confession to the murder of all five of her children. She admitted to smothering them because they were crying. Defense attorneys claim that she was coerced. Samuel, *supra*, at A10.

A similar but lower-profile case was reported shortly before Waneta Hoyt's story hit the news. In that case, Jacqueline Farwell was investigated by police who suspected that she suffocated her 15-month-old son. Warren King & Susan Gilmore, *Authorities Probe Baby's Death: Questions Swirling Around Mom's Role*, PHOENIX GAZETTE, Mar. 24, 1994, at A30. Police plan to exhume the boy's body. Farwell claims he died of SIDS, but he was recorded as having died of a "seizure disorder" in order to perform an autopsy. King & Gilmore, *supra*, at A30.

82. Alexander et al., *supra* note 20, at 585.

83. In the study conducted by Alexander, Smith and Stevenson, three of the five case studies included court testimony of the mother's pattern of abuse with other siblings. See *id.* at 584-85. "[T]he mother's victimization of a previous child was cited as contributing evidence to warrant out-of-home placement." *Id.* at 585.

Smith and Stevenson conclude that in cases involving multi-child Munchausen Syndrome by Proxy, mothers appear to suffer from more serious psychiatric illnesses than those who act only on one child.⁸⁴ Additionally, the results may be influenced by the fact that behavior patterns of the mother with the first child, with whom intervention did not effectively occur, are indicative of behaviors perpetrated on siblings, and thus reinforce intervention with the second child.⁸⁵

B. *The Fathers*

It is atypical in Munchausen Syndrome by Proxy cases for the father to perpetrate the harm caused to the child.⁸⁶ In

The Court of Appeals of Georgia, however, deciding *In the Interest of M.A.V.*, 425 S.E.2d 377 (1992), addressed this issue specifically and reversed the juvenile court's ruling that terminated the mother's parental rights to M.A.V. The juvenile court had terminated the mother's rights to her oldest son based on testimony presented at an earlier hearing concerning her youngest son. *Id.* at 377-78. The testimony suggested that she suffered from Munchausen Syndrome by Proxy and posed a risk to her child. *Id.* at 378. The court of appeals reversed, holding that the child psychiatrist's testimony regarding the mother's treatment of the sibling was not sufficient to establish abuse of the other child by clear and convincing evidence. *M.A.V.*, 425 S.E.2d at 379.

84. Alexander et al., *supra* note 20, at 585.

85. *See id.*

86. V. Faye Jones et al., *The Role of the Male Caretaker in Munchausen Syndrome by Proxy*, 32 CLINICAL PEDIATRICS 245, 246 (1993). Schreier and Libow, writing prior to Faye Jones, cite only 11 published studies incorporating fathers as the primary perpetrator of Munchausen Syndrome by Proxy: S.J. Boros & L.C. Brubaker, *Munchausen Syndrome By Proxy Case Accounts*, 61 FBI LAW ENFORCEMENT BULL. 16, 16-20 (1992); M.S. Dine & M.E. McGovern, *Intentional Poisoning of Children, An Overlooked Category of Child Abuse: Report of Seven Cases and Review of the Literature*, 70 PEDIATRICS 32, 32-35 (1982); V. Godding & M. Kruth, *Compliance With Treatment in Asthma and Munchausen Syndrome by Proxy*, 66 ARCHIVES DISEASES CHILDHOOD 956, 956-60 (1991); A.F. Makar & P.J. Squier, *Experience and Reason Briefly Recorded*, 85 PEDIATRICS 370, 370 (1990); Roy Meadow, *Suffocation, Recurrent Apnea and Sudden Infant Death*, 117 J. PEDIATRICS 351, 351-57 (1990); B. Morris, *Child Abuse Manifested As Factitious Apnea*, 78 S. MED. J. 1013, 1013-14 (1985); J.G. Mortimer, *Acute Water Intoxication as Another Unusual Manifestation of Child Abuse*, 55 ARCHIVES DISEASES CHILDHOOD 401, 401-03 (1980); D.M. Orenstein & A.L. Wasserman, *supra* note 37, at 621-24; M.P. Samuels et al., *Fourteen Cases of Imposed Upper Airway Obstruction*, 67 ARCHIVES DISEASES CHILDHOOD 162, 162-70 (1992); T. Single & R.L. Henry, *An Unusual Case of Munchausen Syndrome by Proxy*, 25 AUSTL. & N.Z. J. PSYCHIATRY 422, 422-25; Y. Zohar et al., *Otolaryngologic Cases of Munchausen's Syndrome*, 97 LARYNGOSCOPE 201, 201-03 (1987). SCHREIER & LIBOW, *supra* note 18, at 22.

Rosenberg's study of 117 cases, the father was indicated as a secondary perpetrator through post-diagnosis collusion in less than two percent of the cases.⁸⁷ One study, however, suggests that while fathers are not typically identified as perpetrators of Munchausen Syndrome by Proxy, the statistics may be severely underestimated because fathers may not demonstrate the patterned behaviors shown by female caretakers. This lack of behavioral symptoms makes detection in males much more difficult.⁸⁸ While fathers typically may not play an active role in perpetrating harm on the child, studies show that it is not uncommon for them to play a passive role in the family's home life.⁸⁹ Denial and disbelief also hinder post-diagnosis paternal involvement.⁹⁰ Often, the father's denial of or inability to accept the behavior of the mother perpetuates the mother's actions because she fears that by admitting her behavior, she will further alienate the father.⁹¹

In the few studies that evidence some active involvement on the part of the father, common characteristics of the male perpetrator include dominance over the female counterpart and hospital staff, exaggerated affection for the child in the presence of hospital staff, and frustration with hospital staff in

87. Rosenberg, *supra* note 20, at 555. Studies reveal that fathers are more typically involved in the disorder, either primarily or collusively, in cases where the behavior begins in older children. SCHREIER & LIBOW, *supra* note 18, at 139.

88. See A.F. Makar & P.J. Squier, *Experience and Reason Briefly Recorded*, 85 PEDIATRICS 370, 372 (1990); SCHREIER & LIBOW, *supra* note 18, at 22-23, 113. *But see* Jones, *supra* note 86, at 247 (explaining that male perpetrators demonstrate commonalities similar to those of female perpetrators, such as a history of psychiatric illness and training in the medical field). Roy Meadow, in personal conversations with Schreier and Libow, has equated male and female characteristics in Munchausen Syndrome by Proxy. See SCHREIER & LIBOW, *supra* note 18, at 23 n.24.

89. See Crouse, *supra* note 43, at 250; Makar & Squier, *supra* note 88, at 372; Mercer & Perdue, *supra* note 30, at 78. See also SCHREIER & LIBOW, *supra* note 18, at 21. The mother's father also plays a significant role in Munchausen Syndrome by Proxy because of the effect the paternal relationship has on the mother. See generally SCHREIER & LIBOW, *supra* note 18, at 98-100 (describing the need for the mother to make up for childhood losses regarding her own father through a relationship with her child's physician as a paternal figure).

90. See Zitelli et al., *supra* note 22, at 1101.

91. Libow & Schreier, *supra* note 62, at 602-11. Guandolo writes that "[n]onintervention by one parent in preventing child abuse committed by the other seems to encourage and perpetuate the abusing parent's detrimental actions." Guandolo, *supra* note 19, at 529.

their failure to diagnose the child accurately.⁹² Some studies reveal that male perpetrators exhibit similar characteristics to those demonstrated by female perpetrators.⁹³ However, because case studies involving the father as a perpetrator are rare, it is difficult to assess accurately whether a similar pattern of behavior can be equally assigned to male and female perpetrators.

One of the few case studies involving the father as a perpetrator suggests four possible explanations for the minimal documentation involving fathers to date: (1) fathers have not been carefully considered as potential perpetrators, therefore, the literature describing such cases is scant; (2) fathers involved in the behavior more actively manipulate professionals because of the mother's non-involvement, therefore, cases with detection are fewer; (3) the role of the male in current society is changing, forcing males to become daily caretakers and thereby experience the same cycle of stress and responsibility as female caretakers in the past two decades;⁹⁴ and (4) the male may demonstrate "protective" behaviors out of a need to maintain and demonstrate his control and protection for the family.⁹⁵ At any rate, the family dynamic plays an important role for both male and female perpetrators. Investigative professionals should carefully assess the behavior of both parents when looking for indications of Munchausen Syndrome by Proxy. As recent studies indicate, careful consideration must now be given to the father as well as the mother.⁹⁶

92. Compare Jones, *supra* note 86, at 246-47 with Makar & Squier, *supra* note 88, at 371-72.

93. See Jones, *supra* note 86, at 247. But see SCHREIER & LIBOW, *supra* note 18, at 113 (noting that the fathers appeared more psychotic and were inspired by motives other than the establishment of a relationship with medical staff).

94. Contra SCHREIER & LIBOW, *supra* note 18, at 115-16 (asserting that society's male and female roles remain gender-biased and consistently perpetuate the father's lack of involvement in childcare).

95. Jones, *supra* note 86, at 247.

96. Guandolo urges that "[t]he psychopathology of the parent who assumes a passive role in cases of child abuse deserves further investigation." Guandolo, *supra* note 19, at 529.

C. *The Children*

As with most forms of child abuse, the victim is often too young to know of his or her predicament⁹⁷ or too incapacitated to tell those in authority.⁹⁸ Unfortunately, in Munchausen Syndrome by Proxy, the victim is always innocently forced to suffer the effects of harmful parental behavior.

The harm to which the child is subjected in Munchausen Syndrome by Proxy exists through direct participation of the perpetrator. For example, the parent may inject the child with a foreign substance,⁹⁹ smother the child into a state of unconsciousness,¹⁰⁰ or simply withhold necessary treatment to exaggerate minor inflictions.¹⁰¹ Harm also occurs indirectly, where, for example, the child suffers physical damage as a result of procedures used in diagnostic or treatment efforts.¹⁰² Other

97. Senner and Ott report that the victim in Munchausen Syndrome by Proxy is rarely over the age of six because at that age a child is usually capable of questioning the perpetrator's actions and speaking to others about those actions. A. Senner & M. Ott, *Munchausen Syndrome by Proxy*, HEALTH & SOC. WORK 53, 53-58 (1989). In one study conducted in 1987 which incorporated data of case reviews from 1966 to 1987, the median age at diagnosis was 3.3 years. Rosenberg, *supra* note 20, at 547-63. Another study indicated median groups under one year old and showed that the age of the child may range from infancy up to eleven years. Mercer & Perdue, *supra* note 30, at 77. The Rosenberg study also indicated almost an equal percentage of male and female victims. Rosenberg, *supra* note 20, at 551. However, Munchausen Syndrome by Proxy has also been diagnosed in cases where the victims have been adults. SCHREIER & LIBOW, *supra* note 18, at 8 (citing Mircea Sigal et al., *Munchausen Syndrome by Proxy: A Psychodynamic Analysis*, 7 MED. & LAW 49, 49-56 (1988)).

98. The child victim often suffers psychological damage as a result of the deceptive behavior of the parent. In some cases, particularly in cases where the child is older, he or she may participate in deceptive practices out of fear and/or become unable to determine what is natural or correct for his or her own body. Mercer & Perdue, *supra* note 30, at 77. Thus, as infant victims become older, they are more likely to participate in their own by-proxy syndrome. SCHREIER & LIBOW, *supra* note 18, at 11.

99. See *supra* note 40.

100. A recent case of Munchausen Syndrome by Proxy involving the smothering of the child was the repeated attempt of Marie Dufour of Atlanta to smother her 17-month-old daughter before and after her admission to the hospital. *Law and Order, Metropolitan Public Safety Report*, ATLANTA. J. & CONST., May 12, 1994, at F3.

101. SCHREIER & LIBOW, *supra* note 18, at 9.

102. Mercer & Perdue, *supra* note 30, at 77. Infants are more typically subjected to induced illnesses perpetrated by the parent, whereas older children are more apt

psychological damage is not uncommon.¹⁰³ For example, children often become fearful of the parent, demonstrate chronic anxiety, hyperactivity and negativism, or simply integrate the passive and self-defeating attitude that is learned in their role as a victim.¹⁰⁴ These learned behaviors in victims often lead to recidivism with their own children or future behavior directed toward themselves as adults.¹⁰⁵

As the medical profession's understanding of the disease has increased, the "classic" victim has become more identifiable. First, the victim usually exhibits of one or more of the commonly fabricated symptoms.¹⁰⁶ Second, discrepancies often exist between the histories presented by the parent and clinical findings of the child's condition.¹⁰⁷ Third, it is typical for the child to cling dramatically to the parent's overprotectiveness and demonstrate inappropriate behavior for his or her age.¹⁰⁸ Fourth, as the child grows older, the child commonly learns to treat his or her symptoms and illnesses as preconditions for his or her mother's love.¹⁰⁹ In cases where the child colludes with

to present with factitious illnesses. SCHREIER & LIBOW, *supra* note 18, at 25-26.

103. See, e.g., McGuire & Feldman, *supra* note 20, at 289-92. For a description of a case where the only risk to the child was psychological damage, see generally SCHREIER & LIBOW, *supra* note 18, at 49-51 (describing that a child was removed from the home but eventually returned to the mother); Mircea Sigal et al., *Munchausen by Proxy Syndrome: The Triad of Abuse, Self-Abuse, and Deception*, 30 COMPREHENSIVE PSYCH. 527, 527-32 (1989).

104. See Mercer & Perdue, *supra* note 30, at 77. For an example of a case study wherein the child eventually grew to participate in the mother's deception by pretending to experience lethargy and pain during hospital visits, see Guandolo, *supra* note 19, at 528-29.

105. See Sigal et al., *supra* note 103, at 527-33. In a study of six patients in four families, McGuire and Feldman report that "[t]he older children and adolescents developed conversion symptoms, cooperated with their parent's deceptions and began to fabricate their own history and symptoms. In these cases and several others . . . the syndrome is clearly multigenerational . . . ; the child victims of Munchausen [S]yndrome by [P]roxy become adult Munchausen syndrome patients." McGuire & Feldman, *supra* note 20, at 291. But see SCHREIER & LIBOW, *supra* note 18, at 27 (suggesting that it is uncommon that children subject to Munchausen Syndrome by Proxy will demonstrate adult Munchausen Syndrome or Munchausen Syndrome by Proxy).

106. See *supra* text accompanying note 30.

107. Crouse, *supra* note 43, at 249.

108. Epstein, *supra* note 35, at 222.

109. Crouse, *supra* note 43, at 250. See also SCHREIER & LIBOW, *supra* note 18, at 140. See generally *id.* at 26-27, 139-43 (noting that children may collude with the

the parent to perpetrate factitious symptoms, it is difficult to determine whether the child is participating in Munchausen Syndrome by Proxy or if the child is involving himself or herself in adult Munchausen Syndrome at a very early age.¹¹⁰ There are, however, noticeable differences in the presentation of the disorder in younger and older children.¹¹¹

Munchausen Syndrome by Proxy may also be perpetrated on the fetus.¹¹² In one such case, a twenty-seven-year-old mother who had previously lost one child after delivering prematurely induced hemorrhaging with a knitting needle during the twenty-sixth week of her third pregnancy.¹¹³ The mother gave birth

parent in fabricating their illnesses because it has become the only "life" that they know in which they are awarded with their mother's affection and describing typical collusive behaviors and responses in adolescent children subjected to Munchausen Syndrome by Proxy).

110. SCHREIER & LIBOW, *supra* note 18, at 9. The youngest child involved in either collusion or early adult Munchausen Syndrome was eight years old. *Id.* Collusion between the parent and child typically occurs when children become victims at an early age and remain victims for a long period of time. *See id.* at 135.

In one case study described by Schreier and Libow, the child, "Danny," colluded with the mother by inducing his own injuries and taking extra pills. *Id.* at 44-48. Evaluators suggested that Danny had developed Munchausen Syndrome. *Id.* at 48. However, Schreier and Libow asserted that "[t]he dynamics of [Danny's] self-medicating would be very different from the usual Munchausen patient's need to be in a relationship with a doctor." *Id.*

111. *See id.* at 135. Observers have noted a difference in the disorder if diagnosed after a child reaches age seven. *Id.* Typically, collusion between mother and child is more frequently seen as a child diagnosed with the disorder at a young age grows older. *Id.* at 143-44. Children who begin the process at an older age are more resistant to the mother's manipulation. *Id.* at 135-36. Younger children are more susceptible to physical harm, while older children are more apt to suffer psychological damage. *Id.* at 145. Also, cases where the disorder begins with an older child sometimes involve active participation by the entire family. *Id.* at 136. These parents are more overtly psychotic. *Id.* at 137. The role of the older child in Munchausen Syndrome by Proxy is to serve the family dynamic, while the younger child is more of an object used to perpetuate the mother's relationship with the physician. *Id.* at 145.

112. *See, e.g.,* Peter W. Gross & Peter N. McDougall, *Munchausen Syndrome by Proxy—A Cause of Preterm Delivery*, 157 MED. J. AUSTRAL. 814, 814-17 (1992) (describing "the first case of Munchausen Syndrome by Proxy involving self-induced preterm delivery"); Jureidini, *supra* note 16, at 135-37 (linking complications in obstetrics to Munchausen Syndrome by Proxy); SCHREIER & LIBOW, *supra* note 18, at 8 (describing Goodlin's 1985 study where the pregnant mother fabricated fetal distress by suppressing the fetal heart rate).

113. SCHREIER & LIBOW, *supra* note 18, at 814. After Munchausen Syndrome by Proxy was diagnosed, the mother eventually admitted in court that she had used a knitting needle to induce labor. *Id.* at 815.

by caesarean section to a son who remained in the hospital for five months before returning home on an apnea monitor.¹¹⁴ During the following seven months, the child was admitted to the hospital five times with unremarkable findings. He returned home and experienced apnea episodes twice per week and was readmitted at eleven, twelve and fifteen months. Health care providers became suspicious of the father and compiled the family history. As a result, Munchausen Syndrome by Proxy was diagnosed.¹¹⁵ The child was taken into custody by social services.¹¹⁶ After a twelve-day hearing contested by the parents, prosecutors proved Munchausen Syndrome by Proxy. Notwithstanding this result, the court returned the child to the mother despite testimony from the doctors who strongly recommended against reunification and felt confident that Munchausen Syndrome by Proxy began prior to the child's birth.¹¹⁷

Other studies have discovered "a significantly increased level of obstetric complications among the population of mothers with [Munchausen Syndrome by Proxy]."¹¹⁸ One reason may be that isolated obstetric complications stimulate the onset of Munchausen Syndrome by Proxy "through unresolved grief, secondary to perinatal bereavement."¹¹⁹ It is also possible that the birth of a child to a mother suffering from Munchausen Syndrome transitions the mother's focus from herself to the child, thus generating Munchausen Syndrome by Proxy.¹²⁰ Whatever the reason, all indications point to the conclusion that instances of

114. *Id.* at 816.

115. *Id.* at 815. The father demonstrated the classical passive behavior of fathers involved in Munchausen Syndrome by Proxy, and although he initially accepted the diagnosis of Munchausen Syndrome by Proxy, he grew to deny the diagnosis with time. *Id.*

116. *Id.* at 815.

117. *Id.* at 816.

118. Jureidini, *supra* note 16, at 135. The conclusions are based on studies of six mothers with a total of 19 children. Fourteen of the children were diagnosed with Munchausen Syndrome by Proxy. *Id.*

119. *Id.* at 137.

120. *Id.* The neonatal period is also significant for a potential Munchausen Syndrome by Proxy mother because it lays the groundwork for the physician/patient relationship that fuels the fire once the child is born. See SCHREIER & LIBOW, *supra* note 18, at 93-94.

fetal Munchausen Syndrome by Proxy are highly underestimated.¹²¹

Regardless of the form of abuse or extent of injury, it is clear that Munchausen Syndrome by Proxy children are both direct objects of abuse and indirect objects used as tools to establish and maintain a relationship between the mother and her physician.¹²² Studies using video surveillance of mothers with their children in the hospital show that the mother appears caring and affectionate while in the presence of others and ignores the child when left alone in the room.¹²³ Such evidence fully supports the theory that the individual and family dynamics of each of the parties involved has much to do with the perpetration of the disorder.

D. *The Social Workers*

Much like medical professionals, social workers typically confront Munchausen Syndrome by Proxy at the identification level. Social workers are most likely to observe the objective signals that lead to further assessment by doctors.¹²⁴ "The mere presence of the child protection agency as a new actor in the case can provide the physician with more leverage to bargain with the mother, and can also prevent the family's flight to another medical center."¹²⁵ Once the disorder is identified, the social worker is also likely to confront the disease through family management. In some instances, the social worker can offer insight to other doctors and lawyers regarding the etiology and symptomatology of the disorder.¹²⁶ It is important, therefore, that the long-term strategy for the family be coordinated through close interaction with the managing social worker and the actual treatment team.¹²⁷

121. See Jureidini, *supra* note 16, at 137.

122. SCHREIER & LIBOW, *supra* note 18, at 97-98.

123. Samuels, *supra* note 86, at 162-70.

124. Mercer & Perdue, *supra* note 30, at 80.

125. SCHREIER & LIBOW, *supra* note 18, at 208.

126. Mercer & Perdue, *supra* note 30, at 80.

127. *Id.* at 79.

Not only does the social worker play an important role in the initial stages of assessment and identification,¹²⁸ but he or she must manage the family once the perpetrator is detected and confronted.¹²⁹ This dual role is especially difficult with parents who may be defensive and in complete denial of their injurious behavior. Of great concern to the social worker is the fact that once the perpetrator is detected and confronted, the family will move to a new treatment facility where their history is not known and the false symptoms can be repeated.¹³⁰ It is important therefore, that social workers present their concerns in a nonaccusatory¹³¹ manner and stress that any allegations and investigations are made with the best interest of the child in mind.¹³² If, in fact, family dynamics have more to do with the

128. One important recommendation for social workers offered by other commentators is that they should be mindful of and play an important part in acquiring and closely reviewing the medical histories of any families suspected of Munchausen Syndrome or Munchausen Syndrome by Proxy. "There often is a pattern of many medical visits and hospitalizations for both the child and the suspected perpetrator, and combing through [the medical records] can be informative." *Id.* at 80.

129. Rosenberg, *supra* note 20, at 558-60.

130. Crouse, *supra* note 43, at 251; see also Asher, *supra* note 54, at 339-41. For a review of a study conducted to determine the relationship between Munchausen Syndrome by Proxy and pediatric patients who are discharged against medical advice, see Jani, *supra* note 45, at 343-49. The study concludes that 64% of the discharge against medical advice cases studied revealed suspicion of Munchausen Syndrome by Proxy. *Id.* at 348.

In one case study presented by McGuire and Feldman, a referral was made to child protective services after the child had been admitted to the hospital several times and health care workers suspected Munchausen Syndrome by Proxy. McGuire & Feldman, *supra* note 20, at 290 (Case 3). However, there was not enough proof to remove the child from the home. Subsequently, the mother left the area, but the child continued to experience symptoms that required hospitalization, including a hospitalization for "jaundice" that was discovered to rub off with alcohol. *Id.* This case study clearly demonstrates the need for clear and convincing evidence of Munchausen Syndrome by Proxy prior to confronting the perpetrator.

131. When confronting the parent, Schreier and Libow recommend being as forthright as possible.

The goal of the meeting is not necessarily to extract a confession . . . but to inform those involved that [Munchausen Syndrome by Proxy] behavior has been exposed, that new steps are going to be taken to protect the child, and that help for the [Munchausen Syndrome by Proxy] mother will be forthcoming.

SCHREIER & LIBOW, *supra* note 18, at 208.

132. See Mercer & Perdue, *supra* note 30, at 80. "A smooth transition to psychological issues allows the pediatrician to help the family with psychological matters and increases the likelihood that the family will accept a referral for psychological

cause of Munchausen Syndrome by Proxy than expected in the past, then it is particularly crucial that social workers maintain a supportive relationship with the family so that the history of the family may be investigated and understood.¹³³ This, in turn, will lead to clearer and more comprehensive information to guide the medical professionals treating the family so they can better respond to the family's needs. Consequently, this "team" of information gatherers—social workers and medical professionals—will be able to define more accurately the framework in which Munchausen Syndrome by Proxy is understood. Therefore, the legal profession will be better able to respond to its consequences.¹³⁴

Social workers play an important role in the multi-professional chain of events involved in Munchausen Syndrome by Proxy. "Designated members of the interdisciplinary team, preferably the primary physician and the social worker, need to pursue the best interest of the child through the evaluation, parental confrontation, legal processes, and the education of other professionals dealing with the family."¹³⁵ It is only through professional interaction that the ultimate goal of safety for the child can be achieved. All of the professional fields involved must come to a better understanding of how to recognize, treat and respond to this confusing disorder.

services, if needed." Richtsmeier, *supra* note 73, at 508 (commenting on results of a case study involving children whose families denied psychosomatic origins).

133. "The optimal assessment of [child abuse] cases requires a comprehensive understanding of the child's situation within his or her family and this requires the integration of [the child's medical findings] with a psychosocial evaluation of the family." Dubowitz & Bross, *supra* note 17, at 598; see also SCHREIER & LIBOW, *supra* note 18, at 204-05 (urging doctors suspicious of Munchausen Syndrome by Proxy to assess thoroughly the medical histories of the child, the child's siblings, and other family members).

134. Commentators discussing the importance of medical documentation assert that effective documentation must be the product of integrated information between the medical and psychosocial assessments and that such documentation should always include an assessment of the likelihood of abuse. Dubowitz & Bross, *supra* note 17, at 598.

135. Mercer & Perdue, *supra* note 30, at 79.

E. *The Doctors*

Doctors are not only confronted with the same identification and investigation hurdles as those faced by social workers, but they also must diagnose and treat Munchausen Syndrome by Proxy. Without the assistance of other professionals, however, diagnosis is extremely difficult. As a result, doctors, more than other professionals, may unknowingly play an active role in harming children of Munchausen Syndrome by Proxy when the disorder is not timely or correctly diagnosed.¹³⁶ In these instances, the child may experience continuing unnecessary medical procedures with potentially fatal results.¹³⁷ Therefore, it is imperative that immediately upon suspicion of Munchausen Syndrome by Proxy, unnecessary and potentially harmful tests and treatments should be discontinued until further assessment.¹³⁸

Particularly when dealing with suspected cases of Munchausen Syndrome by Proxy, doctors are faced with the dilemma of confidently acting on their suspicion.¹³⁹ Just as confrontation runs the risk of even greater hostility and perhaps withdrawal by the parents, false confrontations regarding suspicions of Munchausen Syndrome by Proxy may cause even further harm to the child, either through the breakdown of the relationship between parents and medical staff or through the possible cessation of important tests and treatments. In their article discussing the importance of accurate documentation in cases of

136. Krener & Adelman, *supra* note 30, at 945-51; Zitelli et al., *supra* note 22, at 1101. "It is a telling fact that the medical behavior of a [Munchausen Syndrome by Proxy] mother does not appear to be dramatically different from that of the 'good mother' of a chronically ill child until late in the game when the 'imposter mother' is finally unmasked." SCHREIER & LIBOW, *supra* note 18, at 112. See generally *id.* at 69-72 (explaining how parents of chronically ill children often naturally demonstrate similar behavior as those perpetrating Munchausen Syndrome by Proxy).

137. Zitelli et al., *supra* note 22, at 1101.

138. *Id.* at 1102.

139. "The coexistence of some 'real' medical problems along with symptoms fabricated by the mother is a common occurrence that tends to add to the physician's reluctance to question the genuineness of any of the symptoms." SCHREIER & LIBOW, *supra* note 18, at 40.

child abuse, Dubowitz and Bross clearly depict the dilemma faced by doctors in diagnosing child abuse:

Pediatricians need not allow themselves to be pressured into rendering an opinion that they are not comfortable with. At times, professionals from other agencies are eager to obtain a definitive medical diagnosis even though the data are ambiguous or the pediatrician is unsure of the diagnosis. There can be far-reaching ramifications of the pediatrician's opinion, such as appropriate or inappropriate placement of a child in foster care. . . .¹⁴⁰

The dilemma faced by doctors in diagnosing Munchausen Syndrome by Proxy is especially difficult given the limited understanding of its causes.

Some commentators place a great deal of importance on the relationship between the Munchausen Syndrome by Proxy mother and the physician as a parent or authority figure.¹⁴¹ The dynamics of this theory involve added risk for the child because as the bond between the mother and the physician becomes threatened either through detection or through cessation of symptomatology, the mother becomes defensive. The mother then uses the child to provoke further attention from the physician or to devalue or humiliate the doctor by complicating his assessment of the child's condition.¹⁴²

Any signs of dislike or distancing, or even not believing her story, however subtle, on his part could cause the mother to

140. Dubowitz & Bross, *supra* note 17, at 597.

141. See e.g., SCHREIER & LIBOW, *supra* note 18, at 54, 103-20 (offering a cultural, historical and practical assessment of why the Munchausen Syndrome by Proxy mother is drawn to the medical field and its participants). As Schreier and Libow describe:

The object of this unreal relationship is to connect to a powerful and unattainable person, the doctor, who in fantasy can repair early experienced trauma. The sick child is not the object of this process but rather provides the means for the connection and allows these patients to live out their fantasies, much the way the fetishistic object allows for "sexual activity" for the person with a sexual perversion.

Id. at 81. Some feel that much of the relationship between doctors and patients in the Munchausen Syndrome by Proxy scenario is fueled by the media culture, particularly the depictions of doctors on television in the 1960s and 1970s. *Id.* at 92 & n.8.

142. *Id.* at 96.

up the ante of the deadly game being played out on the child's body, leading to potentially disastrous consequences. The mother often acts to make the symptoms more severe, to prove that she is right and the physician is wrong. Moreover, we believe that sometimes she inflicts harm on the child to take revenge on the doctor who disappoints her.¹⁴³

This interplay between the mother and physician continues until either the mother is detected or the child dies.¹⁴⁴ Added to the already complicated and burdensome predicament for the doctor is his or her¹⁴⁵ subjective care for the child, which is questioned when treatment is unsuccessful.¹⁴⁶ Consequently, the doctor begins to question whether he or she cares enough and to doubt the quality of his or her performance. "These self-doubts in turn cause otherwise competent doctors to miss or misinterpret obvious clues concerning [Munchausen Syndrome by Proxy] behavior."¹⁴⁷

Unfortunately, doctors rely upon therapy, a treatment yet to prove successful, to abrogate Munchausen Syndrome by Proxy.¹⁴⁸ In fact, some commentators feel that "undue reliance on psychiatric evaluation of the parents can lead to unsatisfactory recommendations."¹⁴⁹ The critical factor to be assessed

143. *Id.* at 126-27.

144. *Id.*

145. While physician participants in Munchausen Syndrome by Proxy tend to be male, there is no clear indication that perpetrators seek out male doctors. *Id.* at 28.

146. *Id.* at 130-31.

147. *Id.* at 131.

148. See Zitelli et al., *supra* note 22, at 1102. Schreier and Libow introduce one chapter of their book with a quote from a defense attorney who represented a mother of Munchausen Syndrome by Proxy. The quote accurately describes the frustration faced by all professionals who deal with the difficulty in treating the disorder once it is detected:

I am having trouble having Sandra placed on probation because no one in this area has any expertise with this illness, and it's hard for me to find someone who can take her into treatment. Everyone I talk to about the possibility of long-term treatment says 'We don't have enough data,' or 'For the few cases we have had, we don't think it was very successful.' I find that extremely frustrating, even though I realize there are probably not enough of these cases around and written up in the literature for people to really have expertise with Munchausen by Proxy [Syndrome. But it's incredibly frustrating that I can't find her any help.

SCHREIER & LIBOW, *supra* note 18, at 149.

149. Zitelli et al., *supra* note 22, at 1102.

when recommending treatments, or more particularly, when recommending whether the child should be removed from the home, is the risk presented to the child. This assessment may lead to recommendations that range from outpatient therapy to placement in foster care.¹⁵⁰ However, if a doctor recommends that the child remain at home while the parent receives follow-up care, there is an added risk that the family will relocate or not fully participate in the treatment process.¹⁵¹ In addition, information disclosed during outpatient therapy that would otherwise be helpful to the treating doctor may be privileged because of the patient-therapist relationship.¹⁵² The dynamics of the disorder, in conjunction with the family and individual dynamics, lead the medical concept of Munchausen Syndrome by Proxy into the legal arena which is ill-equipped to respond effectively to the newness of the disorder and its consequences on child welfare.

IV. MUNCHAUSEN SYNDROME BY PROXY AS A LEGAL ENTITY

There is no question that Munchausen Syndrome by Proxy is a form of child abuse. From the initial stages of its discovery to post-diagnostic treatment and criminal prosecution, it is treated as a form of abuse because of the obvious harmful impact it has on its victims. However, Munchausen Syndrome by Proxy is grounded in deception, whereas physical abuse or neglect have more physically tangible signs generating discovery and confrontation. "This disorder is relatively new, and it does not fit very

150. See *id.* at 1102.

151. An added danger in this regard for some doctors is that many times, the doctor does not follow-up on further treatment after the patient and mother "move on" to another doctor or treatment location. The reason for this is that some doctors are relieved to be rid of an overbearing mother or the child's untreatable symptoms. SCHREIER & LIBOW, *supra* note 18, at 131-32.

152. SCHREIER & LIBOW, *supra* note 18, at 162; Zitelli et al., *supra* note 22, at 1102. For a discussion of the admissibility of confidential communications between a client and a therapist in cases involving child abuse, see *infra* text accompanying notes 187-93. It is important to note that therapists find it useful in treating the perpetrators of Munchausen Syndrome by Proxy to distinguish their role of psychotherapeutically treating the patient and his or her problems from assessing the problems in order to make a recommendation to the court regarding the patient's reunification with or separation from the child. SCHREIER & LIBOW, *supra* note 18, at 153-62.

neatly into other categories of child abuse. Nor does it tend to fit the customary physical or psychiatric disorders, which further complicates the process of discovery.¹⁵³ Unfortunately, a disorder that is difficult to detect can cause traumatic results.¹⁵⁴ Thus, when Munchausen Syndrome by Proxy is at issue in the courtroom, judges and lawyers are not only faced with the difficulty of gathering sufficient evidence to proceed in a criminal or dependency matter, but they are also faced with the difficult assessment of how or whether to use such evidence as a means of achieving an appropriate result for the child.¹⁵⁵ However, long before the lawyers and judges are ever confronted with the procedural and evidentiary dynamics of the disorder in the courtroom, physicians, social workers, law enforcement agents, and prosecutors are faced with the legal hurdles that are enmeshed in the confrontational dimension of the disorder. Therefore, notwithstanding the tedious diagnostic struggle that can take months, or even years, Munchausen Syndrome by Proxy carries procedural hurdles for the legal field. If not managed effectively, these hurdles can only exaggerate the harm done to affected children.

A. *Confrontational Difficulties*

The legal difficulties surrounding Munchausen Syndrome by Proxy are typically experienced first by medical or social work staff when suspicions are substantiated and confrontation becomes a viable option. Because confrontation may often result in a negative response from the parent which creates an even greater risk to the child, a pre-confrontational court order to hold the child may be prudent, though not easily obtained given the skepticism that accompanies the disorder.¹⁵⁶ Gathering

153. SCHREIER & LIBOW, *supra* note 18, at 36. "Apparent good or even exemplary parenting, when combined with none of the usual signs of child abuse and no obvious indications of a disturbed parent-child relationship, make it quite difficult to even entertain the possibility of [Munchausen Syndrome by Proxy]." *Id.* at 52 (emphasis added).

154. *See id.*

155. *Id.* at 187. ("[I]t might seem logical to suppose that all U.S. [j]urisdictions would treat this problem with some degree of uniformity, but this has not been the case.").

156. Mercer & Perdue, *supra* note 30, at 80; SCHREIER & LIBOW, *supra* note 18, at

additional circumstantial evidence helps in obtaining pre-confrontational court orders to protect the child from hospital removal. The additional evidence is usually obtained directly from the perpetrator. Evidence may be obtained by searching a suspected perpetrator's personal belongings, but this method poses legal and ethical complications.¹⁵⁷ When these means are pursued, medical professionals have the difficult task of convincing a judge that a search warrant is appropriate and legally justifiable.¹⁵⁸

Video surveillance is one resource used to identify the perpetrator and prove the conduct once Munchausen Syndrome by Proxy is suspected.¹⁵⁹ However, the decision to use video surveillance in an effort to substantiate suspicions can be a difficult decision for the physician because of the possible reactions by the parent.¹⁶⁰ If surveillance is used prematurely or without appropriate safeguards in place to prevent removal of the child, hospitals may be confronted with the same additional dangers to the child's welfare, such as continued onset of symptoms, removal of the child, or even more intensive symptomatology in an effort to prove that the child is actually ill.¹⁶¹

Concerns surrounding the use of video surveillance focus on two areas—the welfare of the child and the legal issues sur-

208.

157. Bernard B. Kahan & Beatrice C. Yorker, *Munchausen Syndrome by Proxy: Clinical Review & Legal Issues*, 9 BEHAVIORAL SCI. & LAW 73, 80-82 (1991); Mercer & Perdue, *supra* note 30, at 79; Zitelli et al., *supra* note 22, at 1102.

158. SCHREIER & LIBOW, *supra* note 18, at 192-96.

159. One expert notes that within a five-year period there were 14 cases of attempted suffocation revealed by hidden video surveillance. James Le Fanu, *Parental Rights, Judicial Wrongs*, SUN. TELEGRAPH, Oct. 24, 1993, at 2. Other studies using video surveillance have proven equally successful. See Diana Brahams, *Video Surveillance and Child Abuse*, 342 LANCET 944 (1993) (claiming 20 saved lives as a result of video surveillance in hospitals); Lorraine Fraser, *Mother Hits Out at 'Abuse' Spy Video*, ASSOC. NEWSP., Apr. 24, 1994, at 13 (confirming abuse in 30 of 34 British cases using video surveillance). For a review of a case study in which video surveillance was used in diagnosing Munchausen Syndrome by Proxy, see Epstein et al., *supra* note 35, at 220-24.

160. "[A]n accused mother can respond with righteous indignation, the decision to remove her child from the physician's care, a lawsuit, or—worst of all—a deliberate effort to make the child very seriously ill in order to prove to everyone involved that she was 'right.'" SCHREIER & LIBOW, *supra* note 18, at 40.

161. *Id.* at 193.

rounding the constitutional protections afforded to the parent. Ultimately, these concerns are weighed by a judge, either before or after video surveillance. However, medical personnel are first confronted with these concerns in a more immediate setting. Therefore, some commentators recommend that "a clinical judgment on the case by a very small group consisting of the consulting pediatrician concerned, a second appropriate consultant colleague [with extensive knowledge of the syndrome], a social worker with statutory authority who deals with child abuse, and a senior nurse involved in the child's care" is warranted to determine whether surveillance is necessary.¹⁶²

Evidence gathered by hospital staff through video surveillance or through miscellaneous gathering of evidence in the hospital room may ultimately serve three purposes, all of which may have other medical or legal ramifications. First, the evidence may serve to confirm suspicions of physicians and nursing staff, which may ultimately lead to further medical and legal action. Second, the evidence sometimes helps when confronting the parents and may assist in revealing the hurtful behavior to the perpetrator, who may then be more likely to admit that there is a problem underlying the behavior.¹⁶³ Third, the evidence assists prosecutors and child protection authorities in criminal and custodial proceedings. Nevertheless, medical and legal procedural and ethical considerations may bar effective use of the evidence.¹⁶⁴ Procedural and evidentiary barriers must be considered prior to gathering evidence since there may be life-threatening consequences for the child.

162. *Id.* at 194 & n.5 (quoting C. Williams & V.T. Bevan, *The Secret Observation of Children in Hospital*, 1 LANCET 780, 780-81 (1988)); see also Brahams, *supra* note 159, at 944 (noting doctors' acceptance of sparing use of video surveillance only after consultation with a multidisciplinary team).

163. Partial admission by perpetrating mothers is not uncommon. See SCHREIER & LIBOW, *supra* note 18, at 123 n.1. However, perpetrators will often deny the abusive behavior despite unquestionable evidence. See *id.* at 19; see also Samuels, *supra* note 86, at 162-70 (assessing that upon confrontation, many perpetrators admit their behavior while minimizing its seriousness).

164. While the safety of the child is obviously the foremost concern, one should not ignore the impact of unfounded covert video surveillance on a family under suspicion. Brahams, *supra* note 159, at 944. However, some commentators justify video surveillance: "By doing covert video surveillance we are betraying the trust of parents. But if a parent has been abusing his or her child in this way then the trust between child and parent has already gone." *Id.* (quoting Professor David Southall).

Additionally, when considering issues such as video surveillance, the courts must weigh the parents' due process and privacy rights as well as protection from unreasonable searches, seizures, and self-incrimination, against the best interest of the child.¹⁶⁵ The exclusionary rule renders inadmissible in subsequent criminal trials evidence illegally obtained by law enforcement officials.¹⁶⁶ However, the United States Supreme Court has held that such otherwise excludable evidence may be admissible when obtained by a private party not acting within the scope of a law enforcement agency.¹⁶⁷ Because hospital personnel act as a private party, any evidence gathered on videotape or through the course of treating a child should be admissible. The importance of such evidence cannot be overemphasized since it is often the only evidence that can begin to confront a judge's inability or unwillingness to accept the reality of the disorder.

B. *Procedural/Evidentiary Difficulties*

Less than a decade after Munchausen Syndrome by Proxy was defined,¹⁶⁸ it was addressed as a legal issue involving evidentiary standards in *People v. Phillips*.¹⁶⁹ In that case, Priscilla Phillips appealed her conviction for the murder of her adopted child. She had allegedly poisoned him in the course of

165. For a discussion of the ethical controversy surrounding the use of video surveillance, compare D.M. Foreman & C. Farsides, *Ethical Use of Covert Videoing Techniques in Detecting Munchausen Syndrome By Proxy*, 307 BRIT. MED. J. 611 (1993) (advocating the use of covert video surveillance under restricted circumstances as ethical) with David P. Southall & Martin P. Samuels, *Ethical Use of Covert Videoing for Potentially Life Threatening Child Abuse: A Response to Drs. Foreman and Farsides*, 307 BRIT. MED. J. 613 (1993) (minimizing the fundamentality of debate over the means by which Munchausen Syndrome by Proxy is diagnosed). See generally Epstein et al., *supra* note 35, at 222-23; Le Fanu, *supra* note 159, at 2 (comparing use of video surveillance in hospitals in cases of suspected suffocation with a Cleveland case involving diagnostic test used to bolster mere suspicions of sexual abuse); D. Southall et al., *Apnoeic Episodes Induced by Smothering: Two Cases Identified by Covert Video Surveillance*, 294 BRIT. MED. J. 1637, 1637-41 (1987); Williams & Bevan, *supra* note 162, at 780-81.

166. *E.g.*, *Mapp v. Ohio*, 367 U.S. 643, 654-56 (1961).

167. *Burdeau v. McDowell*, 256 U.S. 465 (1921).

168. Meadow, *Hinterland*, *supra* note 16, at 343.

169. 175 Cal. Rptr. 703 (Cal. Ct. App. 1981).

what doctors assessed to be Munchausen Syndrome by Proxy.¹⁷⁰ The appeal turned on the admissibility of a psychiatrist's expert testimony regarding Munchausen Syndrome by Proxy. The expert's testimony was based on medical literature that was available up to that point, not the psychiatrist's own personal observations of the mother or of other mothers demonstrating similar symptomatology.¹⁷¹ Phillips did not question the expert's qualifications, nor did she question the trustworthiness of the studies to which the doctor testified.¹⁷² Rather, the mother argued that Munchausen Syndrome by Proxy was an "unrecognized illness . . . not generally accepted by the medical profession" and argued in support of this proposition that Munchausen Syndrome by Proxy was "not listed or discussed as a form of mental illness in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders."¹⁷³ The court ultimately did not accept this reasoning and allowed testimony on the disorder.¹⁷⁴

The *Phillips* court also considered whether the psychiatrist's testimony was admissible when the defendant did not raise her mental state as an issue in her defense.¹⁷⁵ The court of appeals noted that the defendant "maintained that she was completely sane, suffered no diminished capacity and the experts who testified for the defense . . . maintain[ed] that she [had] no mental defect of any kind."¹⁷⁶ On this basis, the defendant argued that testimony regarding Munchausen Syndrome by Proxy was inadmissible. The court of appeals held that the testimony of the psychiatrist regarding the disorder was relevant and admissible to prove or support the mother's motive in behavior that was otherwise "incongruous and apparently

170. The facts involved in the case of Priscilla Phillips follow the same dynamics as typical Munchausen Syndrome by Proxy behavior described throughout this article. See *id.* 705-09.

171. *Id.* at 711-14.

172. *Id.* at 713.

173. *Id.* at 713-14. Munchausen Syndrome by Proxy is now part of the DSM III, which has been revised since 1981. *Id.* at 714 n.2.

174. *Id.* at 714. *Contra In re M.A.V.*, 425 S.E.2d 377, 379 (Ga. Ct. App. 1992) (holding the testimony of a doctor inadmissible because he did not actually examine the child or the mother).

175. *Phillips*, 175 Cal. Rptr. at 711-12.

176. *Id.* at 716.

inexplicable.”¹⁷⁷ The court also held that “[t]he existence, nature, [and] validity . . . of the phenomenon characterized as ‘Munchausen [S]yndrome by [P]roxy’ are all matters sufficiently beyond common experience that expert opinion would assist the trier of fact.”¹⁷⁸ Thus, the testimony was admissible to prove motivation.¹⁷⁹

Expert opinion relating to Munchausen Syndrome by Proxy is also a valuable tool for prosecutors in proving a causal connection between the mother’s actions and the child’s condition. “Expert testimony on the dynamic issues involved would . . . be critical once the attorney has effectively foreclosed all reasonable explanations for the illness.’ The finder of fact should be left with only one reasonable explanation for the child’s illness: the mother caused it.”¹⁸⁰ Thus, the tort law doctrine of *res ipsa loquitur* may be invoked to prove that the mother has caused the child’s illness. This doctrine, while difficult to prove especially in the context of a disorder characterized by deception, was held applicable to Munchausen Syndrome by Proxy in *In re Jessica Z.*¹⁸¹

177. *Id.* at 712.

178. *Id.*

179. The issue of admissible testimony on the disorder is often raised within the context of the *Kelly-Frye* test. This test is used to determine admissibility based on whether the subject in question is generally accepted in the scientific community. *See Frye v. United States*, 293 F. 1013 (D.C. Cir. 1923); *People v. Kelly*, 130 Cal. Rptr. 144 (1976). For a discussion of the *Kelly-Frye* test and its evidentiary value regarding psychological testimony, see Linda E. Carter, *Admitting Matters of Mind*, RECORDER, Sept. 2, 1992, at 7. Munchausen Syndrome by Proxy has been determined not to require the *Kelly-Frye* test for admissibility. *See, e.g., People v. McDonald*, 208 Cal. Rptr. 236-51 (1984) (citing *People v. Phillips*, 175 Cal. Rptr. 703 (Cal. Ct. App. 1981) and declining to apply the *Kelly-Frye* test to expert medical testimony about Munchausen Syndrome by Proxy). However, even if state courts require Munchausen Syndrome by Proxy to meet the same standards as other forms of expert scientific testimony, these admissibility standards may be more liberal in the future in states that have adopted the Federal Rules of Evidence. *See Daubert v. Merrell Dow Pharmaceuticals, Inc.*, 113 S. Ct. 2786 (1993) (liberalizing the standard of admissibility for expert testimony under the Federal Rules of Evidence); *see also Dotto v. Okan*, 1995 WL 42148 (Ill. App. Feb. 1, 1995) (endorsing *Daubert*). *But see State v. Cauthron*, 846 P.2d. 502 (Cal. 1993) (refusing to adopt *Daubert*); *Fishback v. People*, 851 P.2d 884 (Colo. 1993) (declining to endorse *Daubert*).

180. SCHREIER & LIBOW, *supra* note 18, at 191 (quoting J.S. Rypma, *Munchausen Syndrome by Proxy: Detection and Prosecution* (1990) (unpublished manuscript)).

181. 515 N.Y.S.2d 370 (N.Y. Fam. Ct. 1987).

In this case, Jessica's mother abused her by forcing her to ingest laxatives.¹⁸² Jessica consequently suffered severe diarrhea and underwent several surgical procedures to correct what was eventually diagnosed as Munchausen Syndrome by Proxy. After hearing conflicting medical testimony, the Westchester County Family Court of New York concluded that *res ipsa loquitur* clearly applied since no other explanation could be offered to explain the child's condition.¹⁸³ However, the court held that it was in Jessica's best interest to return to her mother's care subject to therapeutic supervision.¹⁸⁴

Prosecutors also face the issue of confidentiality regarding privileged communications made to therapists. They may address and overcome this barrier by a narrow application of applicable state law, which usually restricts privileges when claimed in the context of child welfare issues. For example, in Pennsylvania and most other states, communications between a therapist and patient are protected by statute.¹⁸⁵ However, state law often restricts the umbrella of protection afforded by the privilege by narrowing the scope of protected communications in any proceeding involving child abuse.¹⁸⁶ In Pennsylva-

182. *Id.* at 372-73.

183. *Id.* at 377-78.

184. *Id.* at 378. After considering the risks involved in both removing the child from and returning the child to the family, the court held that confrontation with the mother would halt abusive conduct. Therefore, as long as maximum safeguards were provided, Jessica could remain at home. *Id.* The court further ordered, however, that if at any time the medical professionals involved felt that Jessica was again at risk, Jessica could be removed from the home without first obtaining a court order. *Id.* at 379.

185. The Pennsylvania statute states:

No psychiatrist or person who has been licensed under the act of March 23, 1972 (P.L. 136, No. 52) to practice psychology shall be, without the written consent of his client, examined in any civil or criminal matter as to any information acquired in the course of his professional services in behalf of such client.

42 PA. CONS. STAT. ANN. § 5944 (Supp. 1994) (footnote omitted).

186. *E.g.*, 23 PA. CONS. STAT. ANN. § 6381(c) (1991), which states:

Except for privileged communications between a lawyer and a client and between a minister and a penitent, a privilege of confidential communication between husband and wife or between any professional person, including, but not limited to, physicians, psychologists, counselors, employees of hospitals, clinics, day-care centers and schools and their patients or clients, shall not constitute grounds for excluding evidence at any proceeding regarding child abuse or the cause of child abuse.

nia, Munchausen Syndrome by Proxy clearly falls within the purview of even the narrowest reading of the definition of child abuse.¹⁸⁷ Therefore, communications between parent and therapist would not be afforded the privilege.

State case law further supports the restrictions placed on otherwise privileged communications when a child's welfare is in question. For example, the Superior Court of Pennsylvania has held that testimony of the mother's psychologist at a dependency hearing was admissible despite the mother's assertion of the client-psychologist privilege.¹⁸⁸ In the case of *In re Bender*, the mother participated in a psychological evaluation precipitated by a dependency hearing on another sibling in the family. At the dependency hearing of the child in question, the mother asserted the client-psychologist privilege and opposed the release of information from her evaluation. On appeal, the superior court held that the psychologist's testimony was properly admitted because the mother consented to the evaluation.¹⁸⁹ Even in cases where the parent may not consent to the evaluation, the court stated in dicta that the existence of a true psychologist-client relationship, under which the expectation of confidentiality is formed, does not render the privilege absolute. Rather, the court stated:

[E]ven if we were to concede that a relationship did exist . . . [the] objection must fail . . . [because] there are certain instances where the statutory psychologist-client privilege must yield to disclosure of the communications. If the injury that would inure to the relationship by the disclosure of the communication is less than [sic] the benefit

187. In Pennsylvania, "child abuse" is defined as:

Serious physical or mental injury which is not explained by the available medical history as being accidental, sexual abuse, sexual exploitation or serious physical neglect of a child under 18 years of age if the injury, abuse or neglect has been caused by the acts or omissions of the child's parents or by a person responsible for the child's welfare, or any individual residing in the same home as the child, or a paramour of the child's parent.

23 PA. CONS. STAT. ANN. § 6303 (1991).

188. *In re Bender*, 531 A.2d 504 (Pa. Super. Ct. 1987).

189. *Id.* at 505.

thereby gained for the correct disposal of litigation, then disclosure must be permitted.¹⁹⁰

The court then reasoned:

[W]here the court is concerned with whether the child[ren are] presently without proper parental care and, if so, whether that care is immediately available, we must hold that the injury that would inure to the relationship by the disclosure of the communication is not greater than the benefit thereby gained for the correct disposal of the delicate and complicated societal issues before the court."¹⁹¹

Therefore, under the strict application of state law, communications between a Munchausen Syndrome by Proxy mother and a therapist that are otherwise privileged may and should be disclosed in a dependency or criminal proceeding.

A further complication involving therapeutic testimony on this disorder is simply the sufficiency of the diagnostic evidence. This issue focuses on whether Munchausen Syndrome by Proxy is sufficiently qualified in the medical field to broaden the scope of the legal definition of child abuse. Much of this struggle will depend on, and affect, the converse definitional relationship between the legal and medical fields. The case of *In re Bowers*¹⁹² serves as a perfect example of the paradoxical dilemma created by Munchausen Syndrome by Proxy in the courts. The very language used by the court in *Bowers* expresses the tragic inconsistency in the relationship between law and medicine when dealing with this bizarre disorder.

In *Bowers*, the Athens County Children Services appealed a ruling by the court of common pleas determining that there was insufficient evidence to find the child to be neglected as a result of a diagnosis of Munchausen Syndrome by Proxy.¹⁹³ The lower court heard conflicting testimony from Drs. Clark and Ruhe. Dr. Clark diagnosed the mother with Munchausen Syndrome by

190. *Id.* at 506.

191. *Id.* (citation omitted).

192. No. 1490, 1992 WL 2870 (Ohio Ct. App. Jan. 2, 1992).

193. *Id.* at *1.

Proxy and concluded that the child was at high risk.¹⁹⁴ The court accepted Dr. Clark's testimony as primary evidence on that matter.¹⁹⁵ However, the court was skeptical of the diagnosis because of the lack of physical evidence.¹⁹⁶ It discredited Dr. Clark's testimony because Dr. Ruhe reached a different conclusion, although he did not rule out Munchausen Syndrome by Proxy.¹⁹⁷ Ultimately, the court concluded that the evidence of Dr. Clark's diagnosis failed to meet the prosecution's burden of proof of clear and convincing evidence.¹⁹⁸ The court of appeals upheld that conclusion.¹⁹⁹ In so doing, however, the court of appeals took part in the very tragedy it warned against. The court stated: "Although [Munchausen Syndrome by Proxy] now appears to have been generally accepted as a very real and dangerous condition, there may still be reluctance on the part of some courts to accept this as a bona fide mental illness."²⁰⁰ It goes on to recognize that "the legal system has been criticized as an impediment to managing [Munchausen Syndrome by Proxy] cases because of the skepticism with which those cases are approached."²⁰¹ What the court failed to realize, however, is that it expressly did not utilize the solution that affords protection to Munchausen Syndrome by Proxy victims—a qualified definition of the disorder as abuse of the child. The court admitted: "[W]e adopt no hard rule, or litmus test, for determining neglect or dependency whenever there is a diagnosis of Munchausen Syndrome by Proxy."²⁰² Therein lies the incongruity between the medical and legal perspectives and

194. *Id.* at *4.

195. *Id.* The child experienced diarrhea and vomiting. *Id.*

196. *Id.* at *5.

197. *Id.*

198. *Id.* at *6.

199. *See id.*

200. *Id.* at *3 n.2. In support of this observation, the court cites to *Commonwealth v. Robinson*, 565 N.E.2d 1229, 1238 (Ma. App. Ct. 1991), ("wherein the court, without comment as to the propriety of the decision, noted that the trial court had made an in limine exclusion of expert testimony concerning [Munchausen Syndrome by Proxy] during a mother's involuntary manslaughter trial after the death of her child from 'massive salt intoxication.'). *Id.*; see also *Cohen v. Albert Einstein Medical Ctr.*, 592 A.2d 720, 724 (Pa. Super. Ct. 1991) (holding that the refusal to allow a jury to learn that patient suffered from psychiatric disorder known as Munchausen's Syndrome was reversible error in medical malpractice suit).

201. *Bowers*, 1992 WL 2870 at *3.

202. *Id.* at *4.

the need for a comprehensive approach to understanding, diagnosing and treating the disorder by both fields.

C. *Dispositional Difficulties*

The difficult task of identifying and confronting Munchausen Syndrome by Proxy perpetrators only leads to further procedural stumbling blocks in court. Ultimately, however, the final and most important question faced by any of the professionals involved remains the most difficult to answer: Where do we place the child? Unfortunately, the factors considered in assessing the best interest of the child are baffling because of the social, medical, familial and psychological effects that remain once the disorder is discovered. Such decisions are especially troublesome in less dramatic cases of Munchausen Syndrome by Proxy, thereby making long-term prognosis more difficult.²⁰³ When considering reunification with the mother or family, therapists and judges must also weigh the interests of siblings.²⁰⁴ Of course, much of the decision to reunite the child with the mother, even after long-term intervention, depends on her rehabilitative efforts as well as the nature of the abuse.²⁰⁵ In light of the high percentage of unacceptable development in children who fall victim to the disorder, Roy Meadow concludes that reunification is rarely in the best interest of the child.²⁰⁶ Studies show that children who remain involved with their parents, even during out-of-home placements, fare worse than those who were denied contact with the perpetrating parent.²⁰⁷ Some commentators urge that because these results are consistently unacceptable and because there appears to be no effective rehabilitative treatment for the perpetrator, children should be removed from the care of the parent and the parents' rights to the child should be terminated.²⁰⁸

203. See SCHREIER & LIBOW, *supra* note 18, at 218.

204. See *id.* at 214-15.

205. See *id.* at 215.

206. B. Neale et al., *Problems in the Assessment and Management of Munchausen Syndrome by Proxy Abuse*, 5 CHILDREN & SOC'Y 324, 324-33 (1991).

207. *Id.* at 332.

208. See Robert Kinscherff & Richard Famularo, *Extreme Munchausen Syndrome by Proxy: The Case for Termination of Parental Rights*, JUV. & FAM. CT. J., Nov. 4,

Out of home placement is often prudent because of the continued risk to the child, particularly if the parent denies the allegations.²⁰⁹ Additionally, victims of Munchausen Syndrome by Proxy should not be placed with other family relatives since they often disbelieve the parents are at fault and are more likely to allow continued parental contact.²¹⁰ Such disbelief and corresponding hesitancy to separate the family is not unique to relatives. Both medical and legal professionals involved fall victim to the dynamics of the disorder. Unfortunately, this disbelief, which leads to a reluctance to remove the child from the home, is prompted by a lack of knowledge about the disorder.²¹¹ The public's difficulty accepting the reality of Munchausen Syndrome by Proxy is akin to the inability to accept child sexual abuse twenty or thirty years ago.²¹² Additionally, in many cases where belief is not the stumbling block, lack of proof of the disorder is to blame for failure to remove a child from a perpetrating parent.²¹³ It is important, therefore, to preserve evidence in families with sibling victims through expeditious identification and documentation of the parent's pattern of behavior with the sibling.²¹⁴

1991, at 41, 46.

In March 1993, the Connecticut Superior Court considered the fact that therapy seems to be ineffectual in treating Munchausen Syndrome by Proxy and upheld the sentence of Donna C. DeJesus who was convicted of risk of injury to a minor. *State v. DeJesus*, No. CR92-73269 1993 WL 171866 (Conn. Super. Ct. Apr. 27, 1993). De Jesus requested a reduction of her sentence of eight years, execution suspended after four years, with five years probation, conditioned on having no contact with any children under 18. *Id.* at *1. The reduction request was made because of her diagnosis of Munchausen Syndrome by Proxy. After considering the doctor's testimony that psychotherapy would be ineffectual in treating someone who severely suffered from Munchausen Syndrome by Proxy, the court held that the sentence was not inappropriate to guarantee protection of innocent children. *Id.* at *2.

209. See Crouse, *supra* note 43, at 251; see also, Kinscherff & Famularo, *supra* note 208, at 41-53.

210. See SCHREIER & LIBOW, *supra* note 18, at 209-10; see also McGuire & Feldman, *supra* note 20, at 289.

211. See Zitelli et al., *supra* note 22, at 1101-02; see also SCHREIER & LIBOW, *supra* note 18, at 101, 188.

212. See McGuire & Feldman, *supra* note 20, at 292. Estimates show that because of the increased awareness of child abuse, reports of child sexual abuse have increased twenty-fold since the mid-1970's. See Edmonds, *supra* note 13, at 2A.

213. See, e.g., McGuire & Feldman, *supra* note 20, at 290 (describing cases where the child was returned to the family for lack of proof of the high risk associated with the disorder).

214. See Alexander et al., *supra* note 20, at 584-85. Rosenberg's study supports the

Many of the studies reviewed by commentators suggest that there are several factors to consider in determining whether even *suspected* victims of Munchausen Syndrome by Proxy should be removed from the alleged perpetrator's home:

First, the abuser tends to be skilled in manipulating the system to an extent that the child has already suffered from months to years by the time the abuse is discovered. Second, . . . abuse continue[s] after confrontation of the mother, after involvement of Children's Protective Services, after discovery of abuse of a sibling, and while being closely observed in the hospital. . . . The continuation of abuse during hospital supervision and suspicion of the parent(s) and the recurrence of such behavior after discovery indicates poor parental control of the impulse to harm the child.

Third, both parents' level of denial and their psychiatric diagnosis often mitigate against successful psychotherapy.

Fourth, . . . the absence of fabricated or induced illness does not in itself indicate that the child will thrive in other ways.²¹⁵

These factors are viewed as impediments to intervention and point to the fact that the options available for treating and responding to Munchausen Syndrome by Proxy are ineffectual against a phenomenon that is not yet fully understood.²¹⁶ An especially difficult impediment to removal from the home is the complete absence of physical evidence.²¹⁷ In cases where there are no apparent physical injuries inflicted on the child and the only risk to the child is psychological damage, "child protective and legal systems are reluctant to intervene unless grave physical danger to the child can be proven."²¹⁸

Compounding the physical and evidentiary impediments to intervention is the fact that therapeutic intervention seems to be ineffectual.²¹⁹ This may be due to the parent's lack of com-

urgency of early identification. In this study, 10 of the 117 victims died, and two of these deaths occurred after the children were sent home by the court. *See* Rosenberg, *supra* note 20, at 547.

215. McGuire & Feldman, *supra* note 20, at 291-92.

216. *Id.* at 292.

217. *See, e.g., In re Bowers*, No. 1490, 1992 WL 2870 (Ohio Ct. App. Jan. 2, 1992).

218. SCHREIER & LIBOW, *supra* note 18, at 51.

219. *Id.* at 149-50, 162. For examples of various treatment techniques that have

mitment to therapy or refusal to submit to counseling.²²⁰ Also, therapeutic intervention for a disorder so deeply rooted in personal and familial dynamics requires long-term, intensive, follow-up care, and the parent is not always agreeable.

[M]ost [Munchausen Syndrome by Proxy] mothers are *not* inpatients (medical or psychiatric) and therefore are more difficult to work with in any intensive, ongoing psychotherapy. Opportunities for long-term work with these patients typically occur either in court-ordered, outpatient psychotherapy mandated by a judge in order for the mother to regain custody of her child or children, or more rarely in situations in which the parent experiences an acute psychiatric crisis (becomes suicidal, psychotic, or the like) following exposure of her fabrications.²²¹

Nevertheless, therapy serves as a crucial ingredient for a comprehensive understanding of Munchausen Syndrome by Proxy, and the court will play an important role in regulating its appropriateness for each individual patient.²²² Courts should consider, however, that the newness of the disorder and difficulty in follow-up treatment make it difficult to ascertain the end effect on the child. This is especially true in milder cases of Munchausen Syndrome by Proxy, where the child is returned to the perpetrating parent and eventually ends any follow-up

been attempted, see *id.* at 150-52. For examples of specific therapeutic case studies, see *id.* at 153-61. Because most psychotherapists deal with Munchausen Syndrome by Proxy patients seldomly, if at all, it is difficult to develop expertise in formulating successful treatment plans for the disorder. See *id.* at 153. One suggestion is to alter the expectations of therapy and to divert the patient's attention away from medically oriented behavior. Patients should concentrate on family dynamics, not the more deeply-rooted, subjective personality disorder. *Id.* at 163.

220. *Id.* at 150. Some courts have considered the parent's denial of wrongdoing or refusal to begin therapy when deciding to terminate custody rights. See, e.g., *In re S.R.*, 599 A.2d 364 (Vt. 1991). In *In re S.R.*, the Supreme Court of Vermont upheld the order of the juvenile court terminating rights of both parents where evidence showed that the child "faced a ten-to-twenty percent chance of death based on her parents' denial of [the] disorder. . . . [and] that the risk to [the child] due to that denial increased with the level of stress in the home." *Id.* at 367.

221. SCHREIER & LIBOW, *supra* note 18, at 152.

222. Schreier and Libow, in conjunction with Meadow's assessment of factors to be considered in reunification decisions, enumerate what may be considered "ideal" but "unachievable" criteria for reunification. *Id.* at 218-20.

care.²²³ Therefore, the court must rely on comprehensive and unified assessments of other professionals to identify and stabilize an appropriate disposition suited to a child victim's specialized and continuing needs.

VI. THE NEED FOR A COMPREHENSIVE AND UNIFIED APPROACH

The few commentators who understand the mysterious disorder of Munchausen Syndrome by Proxy agree that the scope of the disorder far surpasses the resources available to respond to it at various levels. In fact, statistics show that more than half of the cases studied result in serious harm to the child.²²⁴ Therefore, because the Munchausen Syndrome by Proxy disorder has various and diverse complications at many levels and stages, the medical and legal responses to the disorder must be comprehensive. Various researchers and commentators have explored how to best respond to this enigmatic disorder.²²⁵ All commentators agree, however, that doctors must lead the movement toward a unified approach, given the degree to which they are involved in the child's care. For example, Roy Meadow suggests that Munchausen Syndrome by Proxy would be more readily detectable in the pre-modern medicine era.²²⁶ In other words, the very nature of the disorder should facilitate extensive conversation with the mother and the extended family as well as promote serious and extensive assessment of the family dynamic. Modern medicine, on the other hand, advocates surging forward with diagnostic procedures based solely on the medical information provided by historical backgrounds.²²⁷

223. *Id.* at 51.

224. Meadow, *Foreword*, *supra* note 23, at x.

225. For a thorough synopsis of suggested guidelines for various stages of Munchausen Syndrome by Proxy for the various professionals involved, see generally SCHREIER & LIBOW, *supra* note 18, at 201-20.

226. Meadow, *Foreword*, *supra* note 23, at ix.

227. For many physicians it is easier to request an investigation, even one that is costly and itself takes several hours, than to spend time talking with the mother. Few medical professionals would doubt that most surgeons would much prefer to do three operations on children, each lasting four hours, than to spend even one hour talking with each of the three mothers of these children. The increased specialization of modern medi-

Meadow questions whether, in some cases, the extent of perpetuation of the disorder by the medical profession itself might qualify Munchausen Syndrome by Proxy as medical negligence.²²⁸

Nevertheless, the difficulties faced by medical professionals plague all professions involved in treating the disorder.²²⁹ Munchausen Syndrome by Proxy is a multi-dimensional dilemma that presents unique difficulties for various fields at various levels and stages of the disorder. Once involved, each professional assumes a key role in addressing the different facets of the disorder. Finally, each of the disorder's complicated facets must be considered and addressed during medical treatment, suspicion, confrontation, disposition, and rehabilitation. A systematic approach at every level and stage is crucial to better understanding and more effectively treating Munchausen Syndrome by Proxy.²³⁰

Id. at ix; see SCHREIER & LIBOW, *supra* note 18, at 212. The consequences of this scenario were illustrated in the case of *In re Jessica Z.*, 515 N.Y.S.2d 370 (1987), where the court heard conflicting testimony from two medical experts regarding the cause of the child's injuries. One doctor diagnosed Munchausen Syndrome by Proxy; the other enumerated several possible causes for the child's injuries. The court accepted the former doctor's testimony as more credible because that diagnosis "was based upon his treatment and observations of [the child's] condition . . . and his recognition of similarities between certain characteristics of [the mother] and the typical [Munchausen Syndrome by Proxy] perpetrator. . . . In contrast, [the other doctor's] testimony was based solely on his review of hospital records and examination of Jessica prior to trial." *Id.* at 375-76; see also, *In re M.A.V.*, 425 S.E.2d 377, 379 (Ga. Ct. App. 1992) (deciding not to consider doctor's testimony because opinions were based solely upon his examination of medical records of a sibling the doctor did not examine).

228. See Meadow, *Foreword*, *supra* note 17, at x.

The United States District Court for the Eastern District of Pennsylvania considered Munchausen Syndrome within the context of contributory negligence in *Ford v. United States*, No. CNA.84-1013, 1987 WL 13347 (E.D. Pa. July 1, 1987), where the court held that the plaintiff was not contributorily negligent for damages suffered from the amputation of her legs as a result of behaviors caused by Munchausen Syndrome. In *Ford*, the court agreed that the behaviors resulting from the plaintiff's disorder "significantly contributed to her physical problems after [her] amputation. . . . But . . . strongly disagree[d] with defendant's view that her behavior may be viewed as contributorily negligent." *Id.* at *10.

229. See McGuire & Feldman, *supra* note 20, at 292; Zitelli et al., *supra* note 22, at 1102.

230. SCHREIER & LIBOW, *supra* note 18, at 202.

First, medical and legal professionals and social workers must believe the disorder exists.²³¹ They must combat "the natural response and desire to believe the story of any parent who is dealing with the difficulties of a child's illness, and who risks losing that child if we disbelieve her."²³² The unique deception perpetrated by Munchausen Syndrome by Proxy parents is compounded by the lulling alliance formed between the physician and the perpetrator who feeds off the doctor's success. Arguably, the fact that the doctor is initially focused solely on the medical presentation of the child stimulates the trusting relationship with the parent. The parent thrives on challenging the physician to solve the dilemma she has created.

Pediatricians are trained to listen to mothers as a source of knowledge and understanding about their child's illness. When a patient presents with . . . serious symptoms . . . pediatricians often narrow their focus in their relentless pursuit of the medical causes. This singular mind-set, understandable in cases where symptoms are dramatic and life threatening, is exactly what makes [Munchausen Syndrome by Proxy] such a difficult disorder to identify.²³³

Therefore, before any profession can begin to develop an individual yet systematic approach to dealing with Munchausen Syndrome by Proxy modern medicine must first accept the reality of the disorder.

However, a comprehensive approach to Munchausen Syndrome by Proxy is dependent on the integration of multidisciplinary assessments. This is only feasible, of course, if the assessment within each discipline is clearly defined and can be integrated into other professions' assessments.²³⁴ This is

231. See *supra* notes 212-14 and accompanying text.

232. SCHREIER & LIBOW, *supra* note 18, at 124.

233. *Id.* at 43.

The problems created by [the parent's] lying in [Munchausen Syndrome by Proxy] for the physician are exponentially greater than those found in a psychotherapy situation where the patient's resistance is anticipated from the beginning. The doctor unknowingly involved with a [Munchausen Syndrome by Proxy] mother *must* rely on her veracity: her baby's life depends upon her truthfulness.

Id. at 126.

234. Dubowitz & Bross, *supra* note 17, at 598-99.

particularly true regarding the integration of the child's psychiatric assessments and the treating pediatrician's assessments.²³⁵ Comparable evidence from many case studies reveals that a very important factor to consider in diagnosing Munchausen Syndrome by Proxy is the family dynamic. The family dynamic includes each family member's medical history, psychiatric history, and current mental or emotional state. To understand fully these aspects that factor into diagnosing Munchausen Syndrome by Proxy, a multidisciplinary approach is crucial. Such an approach will aid each discipline in suspecting, investigating, treating, and reacting to the disorder.²³⁶

Each discipline has a unique perspective and reaction to Munchausen Syndrome by Proxy.²³⁷ One of the most important components for comprehensive integration of these perspectives, particularly for doctors, is documentation.²³⁸ Clear recording of suspicions, investigations, and the written diagnosis of Munchausen Syndrome by Proxy will be sufficient for legal purposes.²³⁹ In the course of compiling documentation however, the physician must validate his or her suspicions through interdisciplinary and intradisciplinary discussions. "[A] team or *group* discussion of a puzzling case can often generate useful observations and validate suspicions more rapidly, overcoming some of the individual obstacles to entertaining [a Munchausen Syndrome by Proxy] diagnosis faced by the lone physician."²⁴⁰ Some commentators call for a central registry as well as for a freely accessible network of information about Mun-

235. Armon Bentovim, *Munchausen Syndrome and Child Psychiatrists*, 60 ARCHIVES OF DISEASES OF CHILDREN 688 (1985); Krener & Alderman, *supra* note 30, at 950; see also SCHREIER & LIBOW, *supra* note 18, at 134 (calling for a willingness of physicians "to share feelings of inadequacy or bewilderment with colleagues").

236. Zitelli et al., *supra* note 22, at 1099.

237. SCHREIER & LIBOW, *supra* note 18, at 189.

238. Dubowitz & Bross, *supra* note 17, at 596-99 (stating that "[a]n accurate documentation of the pediatrician's assessment is important to convey the information to professionals in the public agencies involved, including the legal system"). See generally SCHREIER & LIBOW, *supra* note 18, at 189-91 (discussing the importance of documentation in evidencing that the child's symptoms could only be caused by the mother).

239. Dubowitz & Bross, *supra* note 17, at 597; see also SCHREIER & LIBOW, *supra* note 18, at 190 ("Demonstrating that the child appears to be well while in the hospital in the mother's absence is of enormous legal value.").

240. SCHREIER & LIBOW, *supra* note 18, at 41.

chausen Syndrome by Proxy families for medical professionals.²⁴¹ A registry would serve as an information pool to assist jurisdictions in keeping track of Munchausen Syndrome by Proxy families that continually evade follow-up care through transiency and "hospital-shopping" to satisfy their need for an eager and unsuspecting doctor.²⁴²

Interagency child death review teams would also prove beneficial to understanding Munchausen Syndrome by Proxy.²⁴³ A child death review team generally consists of members from agencies affiliated with case management for children, including but not limited to child protective service agencies, law enforcement agencies, medical examiners, and health professionals.²⁴⁴ Such teams are useful in defining and correcting problems within and among agencies that exist in responding to suspicious cases of child abuse or death.²⁴⁵

241. Kinscherff & Famularo, *supra* note 208, at 48 (calling for an information bank maintained by the National Center for Disease Control); A. Markantonakis, *Munchausen Syndrome by Proxy*, 155 BRIT. J. PSYCHIAT. 130, 131 (1989) (calling for a national registry); Zitelli et al., *supra* note 22, at 1102 (calling for a statewide registry).

242. See generally SCHREIER & LIBOW, *supra* note 18, at 213.

243. For commentary on child death review teams and their clinical relevance, see Durfee et al., *supra* note 13, at 3172-75. The first child death review team was formed in 1978 in Los Angeles, California. By April 1992, 21 states had implemented child death review teams at the state or local level. *Id.* at 3173. Officials hope that by the year 2000, child death review teams will be functioning in 45 states. *Id.* at 3175 (citing HEALTHY PEOPLE 2000: NATIONAL HEALTH PROMOTION AND DISEASE PREVENTION OBJECTIVES, U.S. DEPT OF HEALTH AND HUMAN SERVICES, PUBLIC HEALTH SERVICE (1990)).

244. See *id.* at 3173.

245. Officials hope that child death review teams will help improve the following:

- (1) Interagency communication for management of death cases and for management of future nonfatal cases.
- (2) Accuracy of and capability for criminal, civil, and social intervention for families with fatalities.
- (3) Intervention with surviving and at-risk siblings, including counseling and follow-up.
- (4) Profiles of families at risk for fatal or severe abuse and neglect.
- (5) Intra-agency and interagency systems using cases to audit the total health and social service systems and to minimize misclassification of cause of child death.
- (6) Evaluation of the impact of specific risk factors, including substance abuse, domestic violence, and previous child abuse.
- (7) Interagency services to high-risk families.
- (8) Data collection for surveillance of deaths and for study of categories of death such as bathtub drownings or burns.

The multiagency team process is more vigorous than the single agency process, more capable of clearly identifying a case that is suspicious, and more able to deal with special challenges, such as the difficulty of identifying the perpetrator out of multiple caretakers [and] separating out physical findings that confuse the determination of cause of [symptoms]. . . .²⁴⁶

Multiagency review teams also help agencies and professions learn from the achievements and mistakes of other agencies. This, in turn, will provide a systematic approach to servicing siblings involved in Munchausen Syndrome by Proxy as well as for a learning continuum for individual agencies and professionals.²⁴⁷ The data collected by the review teams can then be used to create specialized review teams in those areas that demonstrate specific patterns and require specialized attention and service.²⁴⁸

A unified and comprehensive approach is not only necessary among different professions, but within each profession. As one study noted:

[O]ften the [case] management was hampered by differing perceptions among professionals, particularly concerning the nature of the abuse itself, and the psychological condition of the mother. Wide differences of opinion sometimes occurred because of the mother's ability to deceive, and to present as perfectly normal women. Many mothers who had already attempted to foster an over close relationship with a pediatrician and nursing staff, now attempted this with their social worker, health visitor, general practitioner or psychiatrist. Where two workers managed a case in close coop-

(9) Relationship with mass media and use of media to educate the public about child abuse prevention.

(10) Intercounty and interstate communications regarding child death. *Id.* at 3174 (Table 2). While the improvements cited above specifically apply to issues of child fatalities, all of the enumerated outcomes may apply to the specific diagnosis of Munchausen Syndrome by Proxy as well.

246. *Id.* at 3174.

247. *Id.*

248. *Id.*

eration, this helped to reduce the potential overdependence and influence on the individual professional.²⁴⁹

This is particularly true at the therapeutic stage.²⁵⁰ At this stage, a collaborative effort at organizing a standard profile of the Munchausen Syndrome by Proxy perpetrator would help to streamline diagnosis for the physician, treatment for the parent, and dispositional decisions for the court,²⁵¹ all of which should focus on the best interest of the child.

In addition to the far-reaching effects Munchausen Syndrome by Proxy has on its innocent victims and professionals that become swept into the whirlpool of deception associated with the disorder, one seldomly studied devastating effect is the financial impact on the health care system. Hospital visits, laboratory tests, surgical procedures, doctor referrals, and technical costs amount to millions of dollars.²⁵² The average hospital cost for one Munchausen Syndrome by Proxy child is estimated to be \$21,000.²⁵³ Moreover, costs continue to accrue after diagnosis because of the continued need for psychotherapy, social service and legal involvement, and possibly, continuing pediatric care.²⁵⁴ However, when weighed against the psychological, social, emotional, and physical effects on the innocent children, financial costs are an insignificant detail.

It is only through a comprehensive approach by all professions involved that each of the issues and unanswered questions associated with the disorder will be effectively addressed.

249. Neale et al., *supra* note 206, at 330.

250. See SCHREIER & LIBOW, *supra* note 18, at 162.

Often many other mental health professionals (for example, the pediatric consultation-liaison psychiatrist, the child's assigned therapist, the court-appointed evaluating psychologist, the mother's private psychotherapist, and so on) are involved, and they work at cross-purposes because of poor coordination of data, limited financial resources for thorough evaluation, and legal constraints on the sharing of data due to confidentiality issues and ongoing legal proceedings.

Id. at 164-65.

251. See *id.* at 165.

252. *Id.* at 32-33; Cahill, *supra* note 44, at Z18 (estimating a \$40 million per year cost covering unpaid bills resulting from Munchausen Syndrome by Proxy).

253. SCHREIER & LIBOW, *supra* note 18, at 33.

254. See *id.*

Herbert Schreier and Judith Libow, researchers whose contribution to the study of child psychiatry has set in motion a more comprehensive understanding of Munchausen Syndrome by Proxy, accurately summarize the far-reaching effect of the disorder within the fabric of each of the professions involved:

Perhaps the most disturbing aspect of our examination of the context of mothers, caregiving, and medicine is the likelihood that unless there is a radical change in many of our basic institutions and social expectations, we can do little to prevent countless future cases of this disorder, even with improved diagnosis and understanding.²⁵⁵

Thus, to combat the disorder effectively, the legal profession must follow the medical field's lead and treat Munchausen Syndrome by Proxy as a form of child abuse.

The case of Ryan Stallings illustrates the importance of a comprehensive understanding of the disorder.²⁵⁶ Ryan Stallings died in September 1989 as a result of ethylene glycol intoxication, a condition prosecutors believed to have been perpetrated by the infant's mother, Patricia Stallings.²⁵⁷ Approximately five months after her arrest, an incarcerated Patricia Stallings gave birth to another child, David.²⁵⁸ A few weeks after his birth, David was admitted to the hospital with symptoms similar to those of Ryan. David was diagnosed with a rare genetic disorder involving the metabolism of amino acids that produces propylene glycol, a chemical almost identical to ethyl glycol. Ethyl glycol was found in Ryan's blood.²⁵⁹ The two

255. SCHREIER & LIBOW, *supra* note 18, at 120. "We need to pool our knowledge and experience in order to develop *clinical profiles* that can help us to distinguish the characteristics of true illness from the same symptoms when induced." *Id.* at 207 (emphasis in the original).

256. *See supra* notes 2-11 and accompanying text.

257. Bower, *supra* note 8, at 1A.

258. Tom Uhlenbrock & Donald E. Franklin, *Diagnosis May Affect "Murder,"* ST. LOUIS POST-DISPATCH, Apr. 3, 1990, at 3A.

259. *Id.* David's disorder, methylmalonic acidemia, is simply treated with vitamin B12. It is believed that Ryan could also have been treated with vitamins. Tom Uhlenbrock, *Baby's Death: Murder, or Flawed Evidence?*, ST. LOUIS POST-DISPATCH, Apr. 4, 1990, at 1A. Methylmalonic acidemia affects approximately one in 48,000 newborns. Michelle Hoffman, *Scientific Sleuths Solve A Murder Mystery*, 254 SCI. 931, 931 (1991).

chemicals are so similar that chemists easily confuse them in laboratory tests.²⁶⁰ Prosecutors pursued criminal charges for Ryan's death despite the evidence that his brother suffered from the same rare genetic disorder. The court excluded evidence of David's diagnosis,²⁶¹ and Patricia Stallings was convicted of first-degree murder in January 1991 and sentenced to life in prison without possibility of parole.²⁶²

Several months later, chemists from St. Louis University became interested in the case and retested frozen samples of Ryan Stallings' blood. They concluded that the original laboratory studies were incorrect and, in fact, Ryan had died from methylmalonic acid.²⁶³ On September 20, 1991, prosecutors dismissed all charges against Patricia Stallings who had served fourteen months in prison.²⁶⁴

VI. CONCLUSION

Regrettably, child abuse is a continuing problem that seems to increase as society becomes more aware of the extent to which it invades our children's lives. As the medical field accurately identifies, diagnoses, and reports new and more complicated suspicions of abuse, the legal field must mold the working

260. Tom Uhlenbrock, *Baby in Murder Case Not Tested For Fatal Disorder*, ST. LOUIS POST-DISPATCH, May 5, 1990, at 14C.

261. The new evidence was excluded because Patricia Stallings' attorney failed to secure an expert medical witness. The court subsequently held that Stallings had inadequate counsel. See Paula Chin & Giovanna Breu, *The Murder That Never Was*, PEOPLE WEEKLY, Dec. 16, 1991, at 111.

262. Hoffman, *supra* note 259; Chin & Breu, *supra* note 261, at 112.

263. See Hoffman, *supra* note 259.

264. *Id.* A similar case of misdiagnosed Munchausen Syndrome by Proxy was reported in July 1993. In that case, pediatricians in Ft. Lauderdale, Florida suspected Angela Cochran of poisoning her son, David, in November 1990. Don Melvin, *No Truth In It; Mother Almost Loses Her Husband, Sons After Infant's Illness Is Misdiagnosed*, CHI. TRIB., Aug. 22, 1993, at 5. Angela originally brought David to the hospital because of persistent vomiting. However, after the child's stomach was analyzed, doctors found ipecac, a substance used to induce vomiting after poisoning. *Id.* David was diagnosed with Munchausen Syndrome by Proxy and was voluntarily admitted to a hospital for psychological tests. Angela was not allowed to visit her son, who was placed in the custody of relatives. *Id.* Her husband was allowed only supervised visits with the child. *Id.* Two months later, after a university doctor reexamined the child's blood, it was determined that he child suffered a rare enzyme deficiency. David was returned to his mother in March 1991. *Id.*

definition of abuse to accommodate medical suspicions and guarantee an appropriate disposition for the child. Even though modern medicine has accepted Munchausen Syndrome by Proxy as abusive behavior, the legal field has been hesitant, perhaps even resistant, to broaden its scope of abuse to include the far-reaching effects of this bizarre and mysterious disorder. However, the law's refusal to accept the disorder as child abuse stems mainly from the fact that many aspects of the disorder remain unknown to doctors and psychologists.

To appreciate fully the integral relationship between the medical and legal definitions of abuse, one must understand that medical and legal professionals will naturally approach the disorder from different perspectives. Consequently, because the natural progression of the disorder runs from the medical arena to the legal arena, courts will depend on the medical perspective in forming a legal perspective of the syndrome and how to deal with it. Because doctors have only recently identified and briefly studied the disorder, the medical profession can offer little to the courts in terms of understanding its causes. What the court does receive, it most often finds unbelievable. Consequently, even when the court accepts Munchausen Syndrome by Proxy as abuse, it often fails to understand or recognize the damaging effects on its victims, as evidenced by the court's ordering ineffective counseling or therapy and the child's return to the perpetrator. Unfortunately, judges begin to understand the disorder through recidivism.

In order to quell the growing number of cases of Munchausen Syndrome by Proxy and to treat existing cases effectively, social service, medical and legal professionals must focus on understanding the dynamics of the disorder and develop a common acceptance of the reality of this disease. This coordination must begin with the identification, confrontation, and treatment of the disorder by social workers and medical specialists and continue to evidentiary, procedural, and dispositional resolutions under the law. Only through a comprehensive integration of resources among each of the professions and professionals involved will the best interests of our innocent children be served.